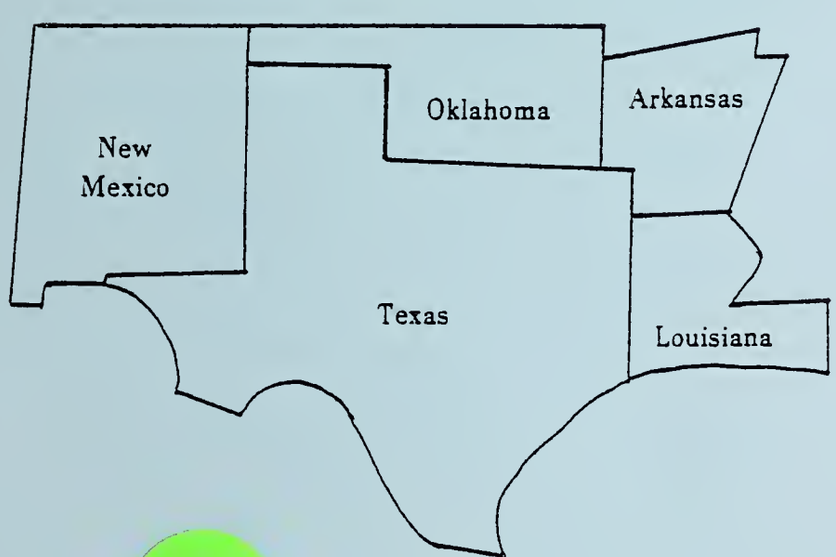
MEDICAID STATE MANAGEMENT REPORT

EFFECTIVE MANAGEMENT PRACTICES

REGION VI



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration

Medicaid Bureau, Region VI

EFFECTIVE MANAGEMENT PRACTICES

Prepared by:

Regional Medicaid Office
Dallas, Texas

November 30, 1980

Contact: Robert Wood (Chief, State operations)
FTS 729-6481 (Dallas TX)

EFFECTIVE MANAGEMENT PRACTICES

Identified by

STATE PROGRAM REPRESENTATIVES

June 30, 1980 - November 30, 1980

Region VI

TABLE OF CONTENTS

	Page
Introduction	ii
Client Placement Service	1
EPSDT Case Management	13
IV-D/Title XIX Third Party Data Exchange	36
Medical Care Advisory Committee	38
Third Party Resource Project	46
Visual Care Program	66

Introduction

The purpose of this report is to summarize those effective management practices identified during the period May 1, 1980 through November 30, 1980. While the Region VI State Assessment activity reflects an exception type of report, this report reflects those activities (practices) implemented by the States that we believe will enhance program management of the Title XIX program.

Each of the management areas follows an identical format: Practice, Purpose, Description, Results, and Contact person. While some of the practices do not result in cost savings, we have also identified those activities that have proved to be beneficial to the State agency or the recipients through greater efficiency, span of control, participation of committee members and providers, and policy input at the grass roots level.

In this effort to identify those practices we believe to warrant recognition we encourage you to explore the feasibility of implementing and/or adapting these practices to your program. You will note a contact person at the end of each summarized subject should you need additional information.

We at the Regional Office are willing to assist and respond to any inquiries you may have.

LOUISIANA

CLIENT PLACEMENT SERVICE

PRACTICE: Comprehensive placement service for eligible individuals and families including residential placement.

PURPOSE: To insure that clients are placed in settings most appropriate to their needs including non-residential, community based residential and institutional programs.

DESCRIPTION: Act 786 passed in 1978 by the Louisiana Legislature required that a client placement division be established to provide comprehensive social services to eligible individuals and families including residential placement. The Act designated the Office of Human Development within the Department of Health and Human Resources (DHHR) as the agency responsible for providing placement services to all DHHR clients in need of such services.

The placement division is charged with seven statutory responsibilities:

1. Assessment of each client's social service needs;

2. Provision of comprehensive diagnostic and evaluation services as needed by each client;

3. Development of a comprehensive service plan based on individual needs;

4. Provision of direct services;

5. Placement of clients in the most appropriate setting including non-residential, community based residential and institutional programs operated by DHHR or public or private agencies with which DHHR contracts for services;

6. Periodic review of client progress and appropriate modification of the service plan; and

7. Termination of services to clients.

In pursuing the goal of placing clients in the most appropriate setting, DHHR follows the concept of the least restrictive alternative in providing treatment. This means treatment that is nearest the client's home, appropriate to the individual's needs and that imposes the least of all possible restrictions on individual freedom. Before removal of any client from his/her home, efforts are directed toward rehabilitating the home environment through the provision of social and financial services to the family. If the client cannot remain in the home, foster care and group homes are considered. The last resort is institutional placement. The ultimate goal is return of the client to his/her home.

The placement process requires for each client a case study including (1) professional evaluations of the client's condition, (2) an individual service plan, (3) review of the service plan by a DHHR Regional Review Committee in the region of the client's residence, and (4) approval of placement by the Assistant Secretary of the Office of Human Development.

The case study (see Appendix A) includes medical, social, psychological or psychiatric and educational (for exceptional children 3 - 21 only) evaluations. From these evaluations, an individual service plan is constructed setting (1) specific goals, (2) identifying expected results and parties responsible for the results, and (3) setting definite time frames for achieving outcomes (see Appendix B).

The Regional Review Committees (RRC) review all cases of DHHR clients for whom the Office of Human Development is responsible for residential placements in settings more restrictive than foster care (see Appendix C). The Regional Review Committees are composed of professional level staff from the Office of Mental Health and Substance Abuse, Office of Mental Retardation, Office of Health and Environmental Quality, Office of Family Security (Long Term Care Unit), each Division of the Office of Human Development, and a medical consultant. The purposes of the review are: (1) to assure that the recommended level of care is the least restrictive and most appropriate needed by the client, (2) to recommend facilities where the treatment can be obtained, and (3) to recommend supplementary services. The Committee is also responsible for periodic reviews of each client to insure that the placement continues to be appropriate.

Certain placements are exempt from RRC review:

1. Adults placed in long term care facilities under the State's Medical Assistance Program for any condition other than mental retardation;

2. Adults (over 21) admitted to State Mental Health Hospitals;

3. DHHR clients admitted to general hospitals for medical care; and

4. DHHR clients admitted to short term Respite Care facilities.

After review the Committee recommends an appropriate facility and support services. The Chair or designee contacts the recommended facility to determine if it will consider the client for placement. When a facility agrees to placement the recommendation is forwarded to the State office.

When a recommendation is received by the State unit from an RRC, the State Placement Director reviews the Committee recommendation and supporting material to determine whether the recommended facility is the most appropriate one available for the client. If so, the facility is contacted to confirm placement.

Services are provided to the family before, during and after placement. Every effort is made to utilize community services to prevent placement. If this is impossible, the case coordinator works with the family to assure that they understand the placement process. After the placed member returns home, services are provided for a time to help the family provide acceptable care for the individual.

RESULTS: Formation of the client placement unit has resulted in a new focus on residential placement. Prior to the unit's development some clients were placed in out-of-State facilities. Now placement is guided by the concept of the least restrictive alternative which means treatment that is nearest the client's home and that imposes the fewest restrictions on individual freedom.

If a child requires care outside his/her home, DHHR attempts to provide such care in a foster home, giving the foster home supportive services to enable it to supply proper care. If the foster care placement is not appropriate or successful, care in a group home is provided as close to the parent's home as possible. Institutional care is the last alternative.

In addition to the concept of the least restrictive alternative, the unit is also guided by the client's right to a program of individualized treatment. The goal of any treatment is to afford the child a reasonable chance to acquire and maintain as high a level of self-sufficiency as possible.

The unit's efforts have also resulted in increased involvement of families in treatment plans and goals. The service plan of every client is a joint effort by case coordinator, client and family. The coordinator assists the client and family to be realistic in developing treatment goals and assures that everyone understands what is expected of him/her.

Placement unit actions have undoubtedly resulted in savings of both State and Federal dollars through the prevention of institutional placement and through the provision of care in less costly settings. Unfortunately cost/benefit statistics have not been maintained. Unquestionably more comprehensive social services have been provided to both clients and families.

FOR FURTHER INFORMATION CONTACT:

John Westbrook, Director
Long Term Care
Office of Family Security
101 Bon Marche
Baton Rouge, Louisiana 70808
(504) 925-3600

APPENDIX A: Case Study

The case study should include professional and social evaluations. Following is a synopsis of the recommended content of these evaluations.

Medical Evaluation

A complete medical evaluation should be secured in order to establish the nature and extent of the client's condition, appraise the general health status of the individual, determine his capabilities and limitations, and ascertain if physical restoration might remove, correct, or minimize the disabling condition. The medical evaluation will serve as a basis for planning to meet the client's medical needs. The examination may range from a general physical to a complete medical work up involving a wide range of tests, depending on the client's disability.

For clients 18 years of age and over, the medical evaluation should also include a statement regarding the client's ability to manage his own affairs unless the client has previously been legally interdicted.

Psychological and/or Psychiatric Evaluation

Psychological evaluations are required for all clients to be placed. In addition, psychiatric evaluations are required for emotionally disturbed clients.

Psychological evaluations shall be current enough to reflect the client's condition at the time placement is considered but shall not be over 12 months old. Psychiatric evaluations shall not be over 6 months old. When the validity of a psychological/psychiatric evaluation is questionable, consultation from the local Mental Health Treatment Center may be requested to determine if another evaluation should be secured.

In the case of mentally retarded clients for whom placement in a long term care facility (ICF-MR) is anticipated, the psychological evaluation should not be over 90 days old at the time of referral to the Regional Review Committee. If a full evaluation is available and appears to be a valid assessment of the client's condition but is over 90 days old, the evaluation may be updated by a licensed psychologist.

Educational Evaluations

For exceptional children ages 3 - 21, an educational evaluation and individualized education plan (IEP) should be requested from the local school board in the parish of the child's residence. As required by P.L. 94-142

and Act 754 of the 1977 Louisiana Legislature, local school boards are responsible for developing an individualized education plan for exceptional children ages 3 - 21. An exceptional child is defined by Department of Education regulations as: gifted and talented, emotionally disturbed, educationally handicapped or slow learning, learning disabled, mentally retarded, hard of hearing, deaf, deaf-blind, speech impaired, severe language disordered, autistic, visually handicapped, multihandicapped, orthopedically handicapped, hospital/homebound or otherwise health impaired or handicapped.

The determination of whether a particular child is "exceptional" should be made by the local school system. The Individualized Education Plan is not required for referral to the Regional Review Committee, but the Office of Human Development case coordinator should cooperate fully with the local school system and the family in an effort to secure an IEP when it is appropriate.

Social Evaluation

Professional evaluations do not always provide a complete profile of the client or his ability to function within his family and the community. It is the responsibility of the case coordinator to complete the case study by gathering additional data about the client's current and previous social functioning to provide a complete understanding of the client's situation. Such information should include the following.

1. Current Situation:

   Description of current placement; client's ability to function in placement, at home, and in school; family or foster family's view of the client; family profile including composition, economic situation, health status, child care used, strengths and needs.

2. Reason for Referral for a restrictive setting or presenting problem:

   Description of specific behavior or condition which has necessitated referral or restrictive setting. An effort should be made to include specific descriptions in this section rather than general phrases such as "exhibits acting out behavior" or "appears immature". More specific behavior should be described such as "throws object", "refuses to eat", etc. In the case of a medical or handicapping condition, the abilities and limitations of the client should be described, i.e., non-ambulatory, uses wheelchair, etc.

3. Background:

   Summary of pertinent facts of family history, placement history, previous psychiatric, medical, educational problems.

4. Resources previously or currently used and outcomes:

Indication of resources the family used to maintain the person at home or ameliorate his condition, including any referrals made by the case coordinator and outcome of services. Summary of the reason a more restrictive setting is needed. Summary of resources or services which have been used and an indication of what resources or services are needed but are not available. Also there should be a statement of whether foster family care has been considered and, if not, the reasons such consideration has not been made.

5. Summary of Evaluations:

State briefly the recommendations of the professional evaluations. If a mandated evaluation has not been secured, state the reason.

APPENDIX B: Service Plan

The following is a suggested format for an individual service plan:

Section 1. Problem or needs of the client

This section should list the areas mutually identified by client and worker as requiring planned action to effect improvement. The problems/needs listed should relate to the original reason for involvement of the Office of Human Development.

Section 2. Expected Outcomes and Results

This section should be used to record the outcomes/results as seen by both the case coordinator and the client.

Section 3. Step-by-step Proposed Action Plan (Service Strategy)

Include here what services or actions are needed, who can perform these services or actions and whether services or actions can be provided in the home.

Section 4. Timeframe

Include the dates projected by the client/case coordinator for the completion of each planned service or activity to be performed by the client or case coordinator.

Section 5. Estimated Date for Review and Update of the Service Plan

Both case coordinator and client are to take part in this review and updating process.

APPENDIX C: Format for Referral to Regional Review Committee

For clients who appear to require placement outside of their homes more restrictive than foster family care, a referral should be made to the Regional Review Committee. The case coordinator is responsible for submitting the case material described in this section.

The case material described below should be presented to the Regional Review Committee in the following format:

Part I. Recommendation for Placement

Part II. Individualized Service Plan

Part III. Case Study
- A) Social Evaluation
- B) Professional Evaluations (Medical, Psychiatric and/or Psychological, Educational)

Part I. Recommendation for Placement

The purpose of this form is to record action of the Regional Review Committee and the State Placement Unit. The case coordinator should initiate the form at the time of the referral to the Regional Review Committee. (Attachment 1)

Part II. Individual Service Plan

A copy of the Individual Service Plan should be attached to the social evaluation.

Part III. Case Study

Social Evaluation

In preparing the social evaluation, the case coordinator should summarize information obtained during the case study to present a clear and accurate assessment of the client, his situation, and all factors influencing the need for placement. The social evaluation need not repeat specific information included in evaluations and on the placement intake form but should summarize pertinent information about the client and his family.

Professional Evaluations

List the evaluations attached by type and source. If a mandated evaluation is not attached, state the reason. Copies of the evaluations should be attached.

DES Form 736
ed

Attachment 1

RECOMMENDATION FOR PLACEMENT

OFS Medicaid #: _____
FADS #: _____
S.S. #: _____

Client Name _____ _____ _____ Birthdate _____
(Last) (First) (M. Initial)

Address _____ Parish _____
(Street

_____ Race _____ Sex _____
(City) (State) (Zip Code)

Disability _____ _____ _____
(Primary) (Secondary) (Tertiary)

Date of Application for Residential Services _____

Was Client Placed on Emergency Basis ___ / ___ Yes ___ / ___ No

If Yes, Date _____

Member Texas Class ___ / ___ Yes ___ / ___ No ___ / ___ DES-Custody ___ / ___ DYS-Custody ___ / ___ Non-Custody

Case Coordinator Name _____ Work Station _____

REGIONAL REVIEW COMMITTEE RECOMMENDATIONS:

EDUCATION RECOMMENDATIONS:

Date of Recommendations _____

Signatures/Agency of Regional Review Committee Members Making Recommendations:

1. _____ Name/Agency
2. _____ Name/Agency
3. _____ Name/Agency
4. _____ Name/Agency
5. _____ Name/Agency
6. _____ Name/Agency
7. _____ Name/Agency
8. _____ Name/Agency

FINAL REGIONAL REVIEW COMMITTEE RECOMMENDATION:

Date _____ Facility FADS #: _____

PLACEMENT APPROVAL:

Facility Name _____ Planning District _____

Effective Date _____ Termination Date _____ Least Restrictive Environment: YES-NO

Public Facility _____ Private Facility _____

Approved _____ Date _____

RECOMMENDATION FOR PLACEMENT
OED/DES FORM 736

PURPOSE:

To record the action of the Regional Review Committee and the State Placement Units on cases referred for residential placement by the Division of Evaluation and Services and the Division of Youth Services.

PREPARATION:

Form 736 is prepared in original and two copies. The case coordinator completes Sections I and II. The Regional Review Committee completes Section III, the State Placement Unit completes Section IV.

Section I - Identifying Information

OPS Medicaid #: Enter client's number. (Enter "none" if no number is assigned).
FADS #: Enter client's FADS number.
S.S. #: Enter client's Social Security number. Application shall be made via Form SS-5 if client does not have a Social Security number.
Client's Name: Enter the name of the person under consideration for placement.
Birthdate: (e.g. 04/21/71)
Address and Parish: Give client's current residential address.
Race: Enter Negro, Caucasian, Oriental, American Indian, or other.
Sex: Male/Female
Disability: Enter any disabling condition(s) the client may have, in descending order of severity.

Section II - Case Information

Date of Application for Residential Services: Enter the date the most current request for placement was made or that need for restrictive placement was identified.
Was Client Placed on Emergency Basis: Check yes if client was originally placed on an emergency basis. If yes, enter the date of the emergency placement in the space provided.
Member Texas Class: Indicate by checking the appropriate block whether or not the client is a member of the Texas class in the Gary W. litigation.
Custody Status: If the child is in DHHR custody, indicate the Division which has responsibility. Check non-custody if DHHR does not have custody.
Case Coordinator Name: Print your name.
Work Station: Enter the name of your office, e.g. DES - Orleans Parish Office, DYS - Orleans Regional Office, etc.

Section III - Regional Review Committee Recommendations (to be completed at the time the case is reviewed by the Regional Review Committee to record action by the Regional Review Committee.)

Regional Review Committee Recommendations: Enter the full recommendations of the Regional Review Committee at the time the client's case is reviewed. Recommendations may include alternative placement arrangements in order of preference as agreed upon by the committee. Additional pages may be attached, if needed.

Education Recommendations: This section should include recommendations for meeting the child's educational needs in cases of exceptional children ages 3 - 21. In the absence of information on which to base recommendations, this section shall be used to record that the necessary information is not available at the time of review.

The recommendations section shall be dated the day of the Regional Review Committee review and shall be signed by all members of the Regional Review Committee reviewing the case.

Final RRC Recommendation: This section should report the results of action taken on the Regional Review Committee recommendations by indicating the facility which was recommended by the Regional Review Committee which has tentatively agreed to take the client. Any additional information pertinent to approval of the placement shall be recorded. The recommended date of the next review of the case by the Regional Review Committee shall be included in this section.

The date in this section shall be the date a final placement was chosen. The FADS number for the facility in which placement is recommended should be entered in space indicated.

Section IV - Placement Approval (for use by the State Placement Unity only)
This section shall record information regarding the approved placement.

Facility Name: Enter facility approved.
Planning District: Enter Planning District where facility is located.
Effective Date: Enter date authorization is effective and placement can begin.
Termination: Enter date authorization terminates.
Least Restrictive Environment: Circle yes if client is in the least restrictive environment appropriate to his needs; circle no if a more appropriate placement or placement closer to the client's home should be sought or developed.
Public - Private Facility: Check appropriate blank for chosen facility.

Approved/Date: The form shall be signed and dated by representative of State Placement Unit approving the placement.

FORM DISPOSITION:

One copy is retained by the case coordinator who originates the form and is filed in the client's case record. The original and one copy is forwarded to the Regional Review Committee.

The Regional Review Committee retains one copy and forwards the original to the State Placement Director.

Upon completion by the State Placement Director copies will be forwarded to:

- The approved facility
- Case coordinator (to be filed in the family record)
- Facility liaison worker (to be filed in the client's record)
- Regional Review Committee
- Department of Education (when indicated)
- Office of Mental Retardation (when indicated)
- Office of Mental Health and Substance Abuse (when indicated)
- Long Term Care (when indicated).

OKLAHOMA

EPSDT CASE MANAGEMENT

PRACTICE: Computer-supported case management system for EPSDT.

PURPOSE: To provide for more effective management of cases, to ensure the timeliness of services, meet program reporting requirements, and provide a data base for improved program evaluation.

DESCRIPTION: The Oklahoma Department of Human Services has a strong client-centered employment program for all AFDC recipients. One of the important support services for assisting a client in obtaining and retaining employment is the assurance that the client and his/her children are all in good health. In addition, with the relatively short length of receipt of AFDC, currently nine months on the average, it is important that the client become familiar with the mainstream of medical care. As a result, DHS combines the mandatory offer of EPSDT services with the development of a self-support plan, shortly after certification.

The delivery of EPSDT services begins with the certification of each AFDC case. When all data for an eligibility determination have been obtained the pertinent information is entered into the case information system (CI File) at the local county terminal. These Assistance Payments cases are "batch" edited each evening by the computer, and exceptions are reported back to the county the following morning. The evening a case clears all edits, the computer generates a message notifying the social service worker of the new AFDC certification.

The message switching system between the AFDC and social services computer files is of prime importance to the delivery of all services including EPSDT. The "certification" notification is one of nine possible messages generated to the service worker regarding the status of the AFDC case. Other messages include: "the application for AFDC has been denied"; "a child has been added to or removed from the grant"; "the case has been closed"; and "this family cannot read and/or communicate in English". (Appendix 1) The computer also scans the Service Information System (SIS) to determine if a social service case exists for the AFDC family. Agency policy provides for the use of a common case identifying number by Assistance Payments and Services, with the service case number being uniquely identified by use of "K" prefix. The common case number greatly facilitates the case match required for the message system.

The message document indicates whether a matching service case exists. If a service case does exist and is active, the message is sent directly to the worker indicated on the SIS. If the service case is closed the message is sent to the county service supervisor for case assignment. When no matching service case exists for a newly certified AFDC case,

the message document is prepared in the format of the SIS data input document (Form K-3A/B, Appendix 2) with matching information on the CI file preprinted on the K-3A/B. The preprinting of this information saves the service worker's time and allows for a higher degree of consistency between the two files.

If information from the CI file is available which will assist the service worker in more efficient delivery of EPSDT services, it is included on the message sheet. All certification message sheets are flagged with the use of asterisks to identify persons in the case who are under 21. The closure message is programmed to identify those cases for which medical eligibility continues after the grant is ended. Transfer messages are flagged to indicate a new AFDC certification or a case with active EPSDT services. The message regarding persons who do not read or understand English is vital to the outreach process for these special cases. To assist the county office in maintaining controls of these messages a supervisor summary page accompanies each delivery of message sheets.

Because of program requirements, administrative control of the face-to-face offer of EPSDT services is vital. As a result, a printout which tracks the face-to-face informing of EPSDT services has been implemented.

When a case is identified through the message switching system as a new AFDC certification, the case number, name, and the names of all family members under the age of 21 are extracted and held by the computer in a "pending" file. Each evening these cases are matched to the SIS file to determine if criteria necessary to document the face-to-face contact has been entered. When all EPSDT documentation data has been entered on the SIS, the tracking information is fed out of the pending file and printed. If on the 45th day from the date eligibility was determined appropriate services for EPSDT have not been entered, a report is generated and sent to each county informing them of the need to document the face-to-face offer. The case appears on this "exception" list until the necessary entries are made on the SIS.

The forms and procedures used to document the face-to-face offer of EPSDT services are also used to document acceptance of the offer and/or request for support services. These are:

K-1 Application and Eligibility Determination (Appendix 4)
K-3A/B Identifying Information (Appendix 2)
K-6 Service Information (Appendix 5).

The application form (K-1) is completed at each offer of EPSDT and filed in the local case record. It documents the client's decision regarding acceptance or declination of EPSDT and any request for support services. It is not a computer input document.

The K-3A/B identifying information form is a data input form and contains demographic information, including the family members' names, birthdates, worker's name, application date, and each family member's unique two digit identifier number. This form is initiated at the time of application and is updated as indicated. A hard copy is computer generated for the local case record with all information maintained on line in the computer as long as the case remains active and for 15 months following closure. After 15 months the information is stored off line on tape but is easily reactivated to the on-line system.

The service information form (K-6) is also a data input form and serves as a worksheet. Various codes are used to record the type service requested, the action necessary to provide the service, the source of service-provision, and the status of service planning. Two dates are recorded on Form K-6, the actual date of the service status and the estimated date by which the service is to be completed. The individual for whom the service has been requested is identified by the family member number assigned to that person on Form K-3A/B. The combination of all this information creates a "line of service". Each "line of service" is computer-assigned a sequence number, by which updates may be made.

The application form, the two data input documents and a narrative recording of events constitutes the information required to document the face-to-face offer of EPSDT. The client indicates his decision regarding acceptance or declination of EPSDT on the application form. A line of service is entered on the SIS for each eligible individual indicating the decision. If the client has accepted EPSDT, the coding system used for the line of service designates whether support services have been requested, whether the request was for a physical screening and/or dental care, and the specific doctor or dentist planned to provide the service.

In addition to the face-to-face offer, written notification of EPSDT service is made by mailing a flier from the State Office at the time of AFDC certification and yearly thereafter as long as the AFDC case remains in active status. The computer generates address cards from information derived off the CI file to use in mailing the fliers. A list of cases for which fliers were sent is retained on microfische cards to provide for audit tracking.

If at the first face-to-face offer of EPSDT it is determined that a family cannot read or understand English, an indicator is placed by the local worker on Form K-3A/B. Each year the worker for these special cases receives a message instructing him to make the necessary arrangements to assure written notification is hand delivered and explained.

Any request for EPSDT service is recorded on the same application form used to document the face-to-face offer of EPSDT. Through the use of on-line edits, the estimated achievement date of service completion cannot be greater than 60 days from the request date. The use of this arbitrary but necessary deadline allows for time to complete followup services if recommended by the physician. It also enables the computer to be programmed to remind the worker of the need to complete the service.

Two reports are generated monthly to assist workers in managing their caseloads, including EPSDT: (1) The "Worker Report to be used for the Month of (current month)" (Appendix 6) and (2) "Cases with Active Lines of EPSDT Service that Exceed the 60 Day Limit". (Appendix 7)

The "Worker Report" lists every line of service by case and family member that has an estimated achievement date for the next month, the current month and all previous months. Through the use of this report the worker is able to organize his field visits without the burden of creating his own reminder system. The "over 60 days" report is an administrative tool which is sent to the county administrator in each local office. With this printout the administrator can clearly identify problem areas and take steps to correct them.

In Oklahoma a claim form has been developed which also serves as the physician's report of abnormalities noted during a screen. (Appendix 8) When this form is returned to the State Office, a copy is immediately forwarded to the local office for use in updating the line of service to show that screening has been completed. It is also used to determine if any followup has been recommended.

The original of the form is processed as a claim through the claims payment stream. All the information regarding the screening findings is coded into a subsystem file of the medical information files. Because screenings are performed by physicians in Oklahoma, diagnosis and treatment, when necessary, is usually initiated at the time of the screening examination. If an abnormality is noted which requires treatment not provided or referred by the examining physician, the computer generates a message (Appendix 9) to the local worker advising him of the need for followup services. This message sheet has proved to be particularly helpful on EPSDT screens initiated by the client at the physician's office, with no prior contact by the service worker.

Dental claims are filed on the claim form used by all other outpatient services. When these claims are posted for payment, the computer generates a message (Appendix 10) to the worker indicating that the initial dental encounter has occurred. This message sheet is the worker's signal that the dental line of service can be updated to completed status.

When a referral for followup is received, a special code indicating the need for followup is used by the worker to terminate the screening line of service. A new line is entered for the provision of the followup service and is not terminated until the initiation of all recommended followup is implemented.

Oklahoma has designated one year intervals as the periodicity schedule for all EPSDT. Based on the code used to terminate the line of EPSDT service, a message sheet (Appendix 12) is prepared eleven months following the last completed screening, alerting the worker to contact the client regarding rescreening. That contact is documented in the same manner as the original offer and starts the EPSDT cycle again.

The identification of physicians, dentists and optometrists who are available to provide EPSDT services is a vital key to service delivery. Each year a printout is prepared from the medical paid claims files indicating those practitioners who have provided an EPSDT service during the year. This listing is sent to county offices to assist them in preparing a list of providers from whom a client may choose.

RESULTS: In Oklahoma, the computer has facilitated accountability, while streamlining of the system has made more time available to the worker for providing basic preventive and developmental family social services including EPSDT.

The computer-supported case management system has resulted in improved administration of the EPSDT program in a number of ways.

-- It has reduced the amount of time service workers must spend in record keeping.

-- It has improved case documentation and caseload management.

-- It has improved the timely delivery of services through computer-generated suspense reports.

-- It has improved measurement of program performance at all levels - worker, county, and State.

-- It has provided a data base that enhances program evaluation and long-range planning.

Future enhancements to the system will include the expansion of inquiry screens to provide instant access by county staff to all case data.

FOR FURTHER INFORMATION CONTACT

Ms. Marilyn Knott
Deputy Supervisor
Division of Services to Adults
and Family
Department of Human Services
Post Office Box 25352
Oklahoma City, Oklahoma 73125
(405) 521-3531

Exhibit 1.....Service Worker Message Sheet

2.....Case Information Form K-3A/B

3.....Tracking of face-to-face Informing of EPSDT Services

4.....Service Application and Eligibility Determination Form K-1

5.....Service Information Form K-6

6.....Worker Report

7.....Cases with Lines of EPSDT Service That Exceed the 60 Day Limit

8.....Claim Form Adm-36-K

9.....Service Worker Message - Follow-up

10.....Service Worker Message - Dental

11.....Provider List

12.....11 Month Message Sheet

C. LOCAL SERVICE WORKER MESSAGE SHEET REGARDING THE STATUS OF AN AFDC CASE WHICH MAY AFFECT SERVICE PLAN/ELIGIBILITY

Program No. TC9Ø1 County Name: Block 1
Run Date: Supvr. No.: Worker Name:
Action Taken: Application Denied/Declined Action Date:
Reason for Action: Effective Date:

DAP Case Number: Case Name: Address:

There is an active matching service case on the SIS file. Determine if this action affects the service plan.

Exhibit 1

OKLAHOMA DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVICES

IDENTIFYING INFORMATION

1	2 WORKER SSA NO. ★	3 LAST NAME, FIRST INIT. ★	4 SUP NO. ★	5 CO ★
	CURRENT WORKER IDENTIFICATION			CASE LOCATION

LY INFORMATION

CASE NUMBER ★	7 CASE NAME ★	8 TYPE OPEN ★	9 MO. DAY YR. SERV. APP. DATE ★	10 MO. DAY YR. ELIG. APPR. DATE	11 MO. DAY YR. ELIG. REDET. DATE	12 TYPE	13 REAS	14 MO. DA ACTION
						TERMINATION ACTI		

STREET ADDRESS	16 CITY	17 STATE	18 ZIP CODE

ARE OF NAME (Last & Init.)	26 MAILING ADDRESS (Street or Box)	27 CITY	28 STATE	29 ZIP CODE

ERRAL ★ URCE	34 FAMILY SIZE	35 MONTHLY GROSS INCOME	36 PERS. CONT

ILY MEMBER INFORMATION

★	51 FIRST NAME ★	52 M. INIT.	53 SURNAME	54 MO. DA. YR. BIRTHDAY ★	55 BIRTH STATUS	56 SEX	57 RACE	58 EDUC.	59 MARITAL STATUS	60 PAY/ REL.	61 LIVING ARR.	62 CO. SERV
MILY MBER												
MBER												

66 CASE TYPE	67 MO. DA. YR. CASE TYPE EFF. DATE	68 OFF STATUS	69 MO. DA. YR. ORIG. STATUS DATE	70 ORIG. CO	71 MO. DA. YR. CURR. STATUS DATE	72 CURR. CO.	73 EMP. STATUS	74 PRIMARY	75 SECONDARY
								D.O.T.	

79 MO. DAY YR. DATE INITIATED	80 STATUS	81 MO. DAY YR. STATUS DATE	82 EARNED	83 CHILD SUPPORT	84 OASI	85 SSI	86 OTHER

IAL SECURITY NO.	92 CROSS REF. NO.	93 CROSS REF. NO.	94 LEFT FAMILY

★	51 FIRST NAME	52 M. INIT.	53 SURNAME	54 MO. DA. YR. BIRTHDAY	55 BIRTH STATUS	56 SEX	57 RACE	58 EDUC.	59 MARITAL STATUS	60 PAY/ REL.	61 LIVING ARR.	62 CO. SERV
MILY MBER												
MBER												

66 CASE TYPE	67 MO. DA. YR. CASE TYPE EFF. DATE	68 OFF STATUS	69 MO. DA. YR. ORIG. STATUS DATE	70 ORIG. CO	71 MO. DA. YR. CURR. STATUS DATE	72 CURR. CO.	73 EMP. STATUS	74 PRIMARY	75 SECONDARY
								D.O.T.	

79 MO. DAY YR. DATE INITIATED	80 STATUS	81 MO. DAY YR. STATUS DATE	82 EARNED	83 CHILD SUPPORT	84 OASI	85 SSI	86 OTHER

IAL SECURITY NO.	92 CROSS REF. NO.	93 CROSS REF. NO.	94 LEFT FAMILY

SAMPLE

WORKER SIGNATURE _____ DATE _____

OKLA. DISBS. ISSUED 2-76 K-3A

OKLAHOMA DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVIC

IDENTIFYING INFORMATION

DITIONAL FAMILY MEMBERS

CASE NUMBER	7	CASE NAME

1	2 WORKER SSA NO.	3 LAST NAME, FIRST INIT.	4 SUP. NO.	5
	CURRENT WORKER IDENTIFICATION		CASE LOCAT	

FAMILY MEMBER NUMBER

51 FIRST NAME	52 M INIT	53 SURNAME	54 MO. DA. YR. BIRTHDAY	55 BIRTH STATUS	56 SEX	57 RACE	58 EDUC.	59 MARITAL STATUS	60 PAY/ REL	61 LIVING ARR	62 CO. SERV

66 CASE TYPE	67 MO. DA. YR. CASE TYPE EFF. DATE	68 OFF STATUS	69 MO. DA. YR. ORIG. STATUS DATE	70 ORIG. CO	71 MO. DA. YR. CURR. STATUS DATE	72 CURR. CO	73 EMP. STATUS	74 PRIMARY 75 SECONDARY D.O.T.

AL 79 MO. DAY YR. DATE INITIATED	80 STATUS	81 MO. DAY YR. STATUS DATE	82 EARNED	83 CHILD SUPPORT	84 OASI	85 SSI	86 OTHER

SOCIAL SECURITY NO.	92 CROSS REF. NO.	93 CROSS REF. NO.	94 LEFT FAMILY

FAMILY MEMBER NUMBER

51 FIRST NAME	52 M INIT	53 SURNAME	54 MO. DA. YR. BIRTHDAY	55 BIRTH STATUS	56 SEX	57 RACE	58 EDUC.	59 MARITAL STATUS	60 PAY/ REL	61 LIVING ARR	62 CO. SERV

66 CASE TYPE	67 MO. DA. YR. CASE TYPE EFF. DATE	68 OFF STATUS	69 MO. DA. YR. ORIG. STATUS DATE	70 ORIG. CO	71 MO. DA. YR. CURR. STATUS DATE	72 CURR. CO	73 EMP. STATUS	74 PRIMARY 75 SECONDARY D.O.T.

AL 79 MO. DAY YR. DATE INITIATED	80 STATUS	81 MO. DAY YR. STATUS DATE	82 EARNED	83 CHILD SUPPORT	84 OASI	85 SSI	86 OTHER

SOCIAL SECURITY NO.	92 CROSS REF. NO.	93 CROSS REF. NO.	94 LEFT FAMILY

FAMILY MEMBER NUMBER

51 FIRST NAME	52 M. INIT.	53 SURNAME	54 MO. DA. YR. BIRTHDAY	55 BIRTH STATUS	56 SEX	57 RACE	58 EDUC.	59 MARITAL STATUS	60 PAY/ REL	61 LIVING ARR.	62 CO. SERV.

66 CASE TYPE	67 MO. DA. YR. CASE TYPE EFF. DATE	68 OFF STATUS	69 MO. DA. YR. ORIG. STATUS DATE	70 ORIG. CO	71 MO. DA. YR. CURR. STATUS DATE	72 CURR. CO	73 EMP. STATUS	74 PRIMARY 75 SECONDARY D.O.T.

AL 79 MO. DAY YR. DATE INITIATED	80 STATUS	81 MO. DAY YR. STATUS DATE	82 EARNED	83 CHILD SUPPORT	84 OASI	85 SSI	86 OTHER

SOCIAL SECURITY NO.	92 CROSS REF. NO.	93 CROSS REF. NO.	94 LEFT FAMILY

PROGRAM-WS
RUN DATE 03/11/80

STATE OF OKLAHOMA
DEPARTMENT OF HUMAN SERVICES

MARILYNN KNOTT

TRACKING OF FACE TO FACE INFORMING OF EPSDT SERVICES

COUNTY NAME-WESTERN

DAP #	PERS CODE	DATE OF ELIG DETERMINATION	CASE NAME	INDIVIDUALS UNDER 21	SIS FAM. MEM. #	SERVICE SOURCE	STATUS	STATUS DATE	TOTAL DAYS
C-000000	E	01/16/80	TURNER JAMIE	TURNER JOHN	13				55

Exhibit 3-A

PROGRAM-WS318

STATE OF OKLAHOMA
DEPARTMENT OF HUMAN SERVICES

MARILYNN KNOTT

TRACKING OF FACE TO FACE INFORMING OF EPSDT SERVICES

COUNTY NAME-WESTERN

DAP #	PERS CODE	DATE OF ELIG. DETERMINATION	CASE NAME	INDIVIDUALS UNDER 21	SIS FAM. MEM. #	SERVICE SOURCE	STATUS	STATUS DATE	TOTAL DAYS
C-000000		11/29/79	TURNER JAMES	TURNER JOHN	11	651	CD	12/14/79	15
				TURNER Lisa	12	651	CD	12/14/79	15

Exhibit 3-B

Exhibit 3-

STATE OF OKLAHOMA
DEPARTMENT OF HUMAN SERVICES

COUNTY_____

APPLICATION AND ELIGIBILITY DETERMINATION FOR SOCIAL SERVICES

Family Name_____ Case Number_____

APPLICATION FOR SERVICES:

A. Service Request For (name)

_____ _____
_____ _____
_____ _____
_____ _____

B. EPSDT/FAMILY PLANNING:

The social worker explained and offered the child health program and related support services (EPSDT) and/or family planning services to me and I have made the following decision regarding my family's using these services at this time:

Name	Health Screening		Dental Needs		Family Planning	
	Accept	Decline	Accept	Decline	Accept	Decline
_____	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐

I need assistance with:

Arranging ☐ Health Screening ☐ Dentist appointment(s)

Transportation to ☐ Health Screening ☐ Dentist appointment(s)

C. Offer of DHS Work Experience (For parents of children who receive AFDC or dependent children ages 18 and older who receive AFDC.)

☐ I want help with securing an assignment of Work Experience to help get a job.

Indian Tribe. I am a member of, or claim affiliation with, the following Indian Tribe(s):_____ _____ _____ _____

I agree to provide the county office of the Department of Human Services all information necessary to verify any statements made in this application and hereby give permission for the Department to obtain such verification. I understand if I have not been notified of the disposition of my application within 45 days, I have a right to request a fair hearing.

_____ _____ _____
Applicant's Signature Date Phone #

STATE OF OKLAHOMA
DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVICES

SERVICE INFORMATION

CASE NUMBER 151

CASE NAME _____

Sequence Number 154	Family Member Number 155	Service Request Code 156	Estimated Achievement or Review Date Mo. Da. Yr. 157	Service Action Code 158	Specific Source of Service 159	Service Source Code 160	Service Status Code 161	Effective Date of Service Status Mo. Da. Yr. 162
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -
		R	- -	A				- -

WORKER SIGNATURE _____ DATE _____

CODES FOR SERVICE STATUS-BLOCK 161

RF Referral/Follow-up
IC Initiated/Completed
RE Referred
IN Initiated
CM Completed
CF Completed/Follow-up
CD Client Decision
SD Source Decision
JD Joint Decision
AD Agency Decision
UD Unexpected Development
UF Unexpected Development/Follow-up
MV Moved or Cannot Locate
DH Death
NA Not Available
OT Other

WORKER REPORT

DATE 08/16/80 COUNTY STATE OFFICE
KER SIS UNIT EMP NO 333333333 TO BE USED FOR THE MONTH OF 09-80 SUP. 03

ASE BER	CASE NAME	ELIG REDETER	SERV DUE	K-6 SEQ NUM	FAM MEM NUM	K-7 SEQ NUM	SERV REQ	EST ACHV DATE	SERV ACT	SPECIFIC SOURCE OF SERVICE	SERV SRCE CODE	SERV STAT CODE	EFF DA OF SER STATUS
99999	SHILEY	110179											
99999	SHARP	040180	P	018	14		R07	061580	A352	M KNOTT	601	IN	031280
	SHARP		P		02	01	R04	030180	P363	DANDY CARE	804	IN	080879
	SHARP		P		15	01	R06	081580	A102	DR SMITH	651	RE	061780
99999	SHUCKERS	000000											
99999	SEARLE	030180	C	006	11		R44	091580	A365	LISSA FINLY FH	808	IN	121579
	SEARLE		C	007	11		R44	091580	A386	PATTY METZ	601	IN	121579
	SEARLE		P		12	02	R24	031580	P363	CINDERELLA DCC	804	IN	021479

Exhibit 6

DEPARTMENT OF HUMAN SERVICES

WS470 CASES WITH ACTIVE LINES OF EPSDT SERVICE THAT EXCEED THE 60 DAY LIMIT PAGE 1

03/09/80

00 STATE OFFICE SUPV NO-01

CASE NUMBER	FAMILY NAME	SURNAME	FIRST NAME	MEMBER NUMBER	BLK 154 SEQ NO	SERVICE REQUEST	SERVICE ACTION	SERVICE SOURCE	SERVICE STATUS	EFF DATE	TOTAL DAYS
WKR-333-33-333 SIS UNIT KC000000	TURNER	SMITH	JAMES	1	013	R06	A102	651	RE	110179	130

COUNTY TOTAL 1

Exhibit 7

STATE OF OKLAHOMA
DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVICES

PHYSICIANS' REPORT AND CLAIM FOR EARLY PERIODIC SCREENING AND RELATED PROCEDURES

ician's Identification

me

dress — Street or Box No.

y | State | Zip Code

lephone Number | Physicion's Social Security Number

Patient's Identification:

DISRS Case No. | Social Service Number

Name

Address | County

Birthdate | Sex | Race

uest that services compensable by the Department be paid direct to the claimant: _____

Signature of Potient, Parent, Guardian, or Responsible Person (Underline which)

T I. EXAMINATION REPORT

Type of Test or Examination	Normal A	Not Indicated B	Abnormal C	Treated	or Referred	Tr. Not Indicated	Describe Treatment or if Referred state to whom or which Facility
Visual				T	R	N	
Hearing				T	R	N	
Teeth				T	R	N	
Test for Anemia				T	R	N	
Test for Sickle Cell Anemia				T	R	N	
Test for Lead Poisoning				T	R	N	
Speech				T	R	N	
Cordiac Exam.				T	R	N	
Orthopedic Exam.				T	R	N	
Mental Development				T	R	N	
Social Development				T	R	N	
Growth & Nutrition				T	R	N	
Immunization Status				T	R	N	
Unclothed Physical				T	R	N	
Other (Specify)				T	R	N	

Follow-up for further diagnosis or treatment is indicated.
No ☐ Yes ☐
If yes, Date _____

Child is ☐ will be ☐ in my continued care.

Immunization given: (check)
DPT 1 2 3 Booster 4 5
DT 1 2 Booster ☐
TOPV 1 2 3 4 5
Rubella 1
Measles 1
Mumps 1

T II. PHYSICIAN'S CLAIM

Date Examined	Place	Procedure (describe if laboratory or X-ray performed)		Diagnosis (if applicable)	Charge	Leave Blank
		Screening Examination	9607			
				TOTAL CHARGES $		

is to certify that the foregoing information is true, accurate, and complete, and that I understand that payment and satisfaction of this claim will be from ral and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or e laws. If the patient is a recipient of public assistance (money payment) or a ward of the Department of Institutions, Social and Rehabilitative Services, ent received from the Department represents full payment for services rendered this patient during the compensable period. If the patient is a recipient of cal services authorized by the Department for payment from Medical Assistance, or Crippled Children's funds, it is understood that the payment received the Department represents full payment for services rendered this patient during the compensable period, except that the vendor may collect an amount not xceed that shown on the authorization. The signature of the Claimant certifies that services were personally rendered by him. I hereby agree to keep such rds as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding payments claimed for providing such services as the State agency may request for three years from date of service. I further state that the (work, services, aterials) as shown by this invoice or claim have been (completed or supplied) in accordance with the plans, specifications, orders or requests furnished me. ther state that I have made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly, to any elected official; officer or em- ...s of the State of Oklahoma, of money or any other thing of value to obtain payment or the award of this contract; and that I am duly authorized to make this ...t.

MD ☐
DO ☐ _____ *Claimant*

scribed and sworn to before me

_____ 19 ___ _____ *Notary Public*

Commission expires: _____

PF-576
RUN D11/11/79

SERVICE WORKER MESSAGE
ADM-36K
MATCHED TO SIS FILE

COUNTY WESTERN

SUPV NO-01 WRK NAME-SMITH
CASE NO-KC000000
CASE NAME BANNER

CLIENT'S ADDRESS 708 S. WOODS
HOLLIS
OK 73550

PATIENT'S NAME DAVID BANNER

DATE OF EXAMINATION 10/31/79
AREA OF ABNORMALITY
03 TEETH

CHILD HEALTH SCREENING INDICATES AN ABNORMALITY HAS BEEN DIAGNOSED FOR THE ABOVE CHILD. REVIEW FORM ADM-36-K TO DETERMINE IF FOLLOWUP IS INDICATED IN ACCORDANCE WITH MANUAL 551.7. IF FORM ADM-36-K HAS NOT BEEN RECEIVED, REQUEST THAT A DUPLICATE BE SENT FROM STATE OFFICE, DIVISION OF SERVICES TO ADULTS AND FAMILIES. WHEN FOLLOWUP IS INDICATED, A CONTACT WITH THE FAMILY IS MADE TO ARRANGE FOR THE REQUIRED TREATMENT. THE TREATMENT MUST BE INITIATED WITHIN 120 DAYS OF THE DATE OF THE CLIENT'S REQUEST FOR SCREENING SERVICE

Exhibit 9-A

PF-576
DATE 11/22/79

ADM-36K MESSAGE SHEET
UNMATCHED TO SIS FILE

COUNTY WESTERN

PATIENT'S NAME JAMIE TURNER

BIRTHDATE 00/00/00
PA CASE NUMBER C000000
DSS CASE NUMBER AS SHOWN ON ADM-36K KC000000
DATE OF EXAMINATION 10/16/79
AREA OF ABNORMALITY
03 TEETH

THE SIS CASE NUMBER INDICATED FOR THIS CLIENT ON THE ADM-36-K SUBMITTED AS RESULT OF A CHILD HEALTH SCREENING EXAMINATION FOR A CLIENT IN YOUR COUNTY DOES NOT MATCH TO ANY CASE NUMBER CURRENTLY SHOWN ON THE SIS FILE. PLEASE DETERMINE IF THIS INDIVIDUAL APPEARS IN ANOTHER SIS CASE OR IF A NEW SIS CASE NEEDS TO BE OPENED. IF THIS CLIENT APPEARS ON A CASE IN ANOTHER COUNTY, FORWARD THIS MESSAGE SHEET TO THE APPROPRIATE COUNTY.

CHILD HEALTH SCREENING INDICATES AN ABNORMALITY HAS BEEN DIAGNOSED FOR THE ABOVE CHILD. REVIEW FORM ADM-36-K TO DETERMINE IF FOLLOWUP IS INDICATED IN ACCORDANCE WITH MANUAL 551.7. IF FORM ADM-36-K HAS NOT BEEN RECEIVED, REQUEST THAT A DUPLICATE BE SENT FROM STATE OFFICE, DIVISION OF SERVICES TO ADULTS AND FAMILIES. WHEN FOLLOWUP IS INDICATED, A CONTACT WITH THE FAMILY IS MADE TO ARRANGE FOR THE REQUIRED TREATMENT. THE TREATMENT MUST BE INITIATED WITHIN 120 DAYS OF THE DATE OF THE CLIENT'S REQUEST FOR SCREENING SERVICE

Exhibit 9-I

PF-576
RUN D11/22/79

SERVICE WORKER MESSAGE
ADM-36K.
MATCHED TO SIS FILE

COUNTY WESTERN

SUPV NO-06 WRK NAME-DOWNS A
CASE NO-KC000000
CASE NAME TURNER

CLIENT'S ADDRESS P O BOX 111
SULPHER
OK 73086

PATIENT'S NAME JAMIE TURNER
THIS CHILD IS IN DOCTOR'S CONTINUING CARE
DATE OF EXAMINATION 10/24/79
AREA OF ABNORMALITY
03 TEETH

CHILD HEALTH SCREENING INDICATES AN ABNORMALITY HAS BEEN DIAGNOSED FOR THE ABOVE CHILD. REVIEW FORM ADM-36-K TO DETERMINE IF FOLLOWUP IS INDICATED IN ACCORDANCE WITH MANUAL 551.7. IF FORM ADM-36-K HAS NOT BEEN RECEIVED, REQUEST THAT A DUPLICATE BE SENT FROM STATE OFFICE, DIVISION OF SERVICES TO ADULTS AND FAMILIES. WHEN FOLLOWUP IS INDICATED, A CONTACT WITH THE FAMILY IS MADE TO ARRANGE FOR THE REQUIRED TREATMENT. THE TREATMENT MUST BE INITIATED WITHIN 120 DAYS OF THE DATE OF THE CLIENT'S REQUEST FOR SCREENING SERVICE.

Exhibit 9-C

WS314

SERVICE WORKER MESSAGE
EPSDT

MARILYNN KNOTT

COUNTY WESTERN

SUPV NO-01 WRK NAME-DOWNS
CASE NO-KC000000
DAP CASE NO-C000000
CASE NAME-TURNER

CLIENT'S ADDRESS
P O BOX 111
SULPHUR ,OK 73086

PATIENT'S NAME JAMIE TURNER
DATE OF EXAMINATION 11/21/[illegible]
DENTIST'S NAME BOWERS BRANDON

ACCORDING TO THE PAID CLAIMS FILE THIS CHILD RECEIVED A DENTAL EXAMINATION ON TH ABOVE DATE.

Exhibit 10

VENDOR NAME	ADDRESS 1	ADDRESS 2	ADDRESS 3	ZIP CODE	VENDOR CODE
DENTISTS					
SMITH JOHN B DSS	100 PERSIMMON RIDGE	SPRINGDALE ARK		80031	9
OPTOMETRISTS					
JONES ROBERT S OD	201 SW 23	DENVER CO		45002	3
PHYSICIANS					
BROWN MICHAEL C MD	123 CANYON CIRCLE	LOS ANGELOS CA		93023	38
REED JIM L DO	404 E 15	NEW YORK NY		12045	4

Exhibit 11

WS583

DEPARTMENT OF HUMAN SERVICES
SERVICE WORKER EPSDT PERIODIC SCREENING REMINDER

RUN DATE:02/27/80

COUNTY WESTERN

SUPV NO:01 WRK NAME: DOWNS A
CASE NO:KC000000
CASE NAME: TURNER

CLIENT'S ADDRESS: P O BOX 111
SULPHUR, OK 73086

PATIENT'S NAME:JAMES TURNER
DATE OF LAST PHYSICAL EXAMINATION:03-08-79

THIS CONTINUES TO BE AN ACTIVE AFDC CASE. THIS CHILD WAS SCREENED ON THE ABOVE DATE. PRIOR TO VISIT ASSURE THAT CHILD CONTINUES TO BE ELIGIBLE. PLEASE CONTACT THE FAMILY WITHIN THE NEXT THRITY DAYS TO DETERMINE IF THE FAMILY REQUIRES ASSISTANCE IN ARRANGING FOR THE CHILDS PERIODIC SCREENING. AFTER THE NECESSARY ACTION AND UPDATING OF THE SERVICE CASE THIS REMINDER MAY BE DESTROYED

Exhibit 12

Exhibit 12

NEW MEXICO

IV-D/TITLE XIX TPL DATA EXCHANGE

PRACTICE: The New Mexico IV-D agency has agreed on an informal basis to provide to the Title XIX TPL unit mailing information on newly certified IV-D cases.

PURPOSE: The data which is provided by the IV-D agency is utilized by the Title XIX TPL unit to ascertain if absent IV-D parents have medical coverage for IV-D recipients.

DESCRIPTION: The State TPL unit utilizes a form letter which is mailed to the absent parent (see attachment). The letter solicits information on the availability of medical coverage from the absent parents for IV-D recipients. If a positive reply is received from the inquiry the following actions are taken:

1. The State's data files are checked to see if the reported TPL source is currently in file. If the data is not in file the record is updated.

2. Secondly, a recipient payment history is reviewed to ascertain if any prior medical expenses have been paid which the TP source could have paid. If a payment is possible the case is referred for post-pay recoupment if the amount is within the State's tolerance for recoupment.

RESULTS: The State had made one major query under the system and is preparing a second mailing utilizing the attached new revised questionnaire. Based on the initial mailing it is visualized by the State that the system will identify TPL resources which have previously gone untapped for individuals in the IV-D program. The system also holds the potential for establishing the groundwork for a future IV-D/Title XIX cooperative agreement for TPL development.

FOR FURTHER INFORMATION CONTACT:

Gerald Garcia, TPL Coordinator
Medical Assistance Bureau
Department of Human Services
Post Office Box 2348
Santa Fe, New Mexico 87503
(505) 827-5551
FTS: 8-476-5551

STATE OF NEW MEXICO

GOVERNOR'S CABINET

HUMAN SERVICES DEPARTMENT

SANTA FE, NEW MEXICO 87503

MEDICAL ASSISTANCE BUREAU

BRUCE KING
GOVERNOR

LAWRENCE B. INGRAM
SECRETARY

Dear Parent:

In order to assist us in handling claims for medical services provided to your children receiving AFDC, please complete the attached form and return it to us in the enclosed envelope as soon as possible.

If you do not carry insurance for these children, please fill in your name and address, mark "NO INSURANCE" across the form and return it to us.

It is important that all health insurance coverage you have for these children be included on the form. If you need additional space, please use the back of the form.

Thank you for your cooperation in returning the completed form.

Sincerely,

Gerald Garcia, *Administrator*
Third Party Liability Unit

DETACH HERE and RETURN in the ENCLOSED ENVELOPE

HUMAN SERVICES
COME SUPPORT DIVISION

Official and Confidential
INSURANCE COVERAGE STATEMENT
Please TYPE or PRINT

You are encouraged to include your children receiving AFDC in ALL your health insurance policies - *if you have not already done so.*

COMPLETE and RETURN THIS FORM in the ENCLOSED ENVELOPE

Indicated is all insurance I carry which may cover medical expenses for my children receiving AFDC. I will notify the NM Human Services Department whenever I purchase additional insurance or cancel insurance which covers medical services for my children receiving AFDC.

Insurance company name and address

Refer to Medicaid number:

Name(s) of child(ren) covered:

Policyholder/Employer name and address - *if other than you*

Your name and address

Policy number

Date expires

Your signature

Date signed

Insurance type - *Check one*

☐ Auto ☐ Private Health ☐ CHAMPUS
☐ Group ☐ Other:

LOUISIANA

MEDICAL CARE ADVISORY COMMITTEE

PRACTICE: Federal Regulations mandate that a Medical Care Advisory Committee be established and used to advise the Medicaid agency about health and medical care services. The State of Louisiana Title XIX agency has taken these regulations literally and has focused a great deal of effort into developing a mechanism that provides invaluable service to both the Medicaid program and the Medicaid recipient.

PURPOSE: To provide for more efficient utilization of the Medical Care Advisory Committee as a program and management resource.

DESCRIPTION: The Medical Care Advisory Committee meets on a bi-monthly basis. Fifteen days prior to each meeting a reminder notice including agendas for the committee and the subcommittee meetings is mailed to each member. Also included with the notice is a summary of prior committee and subcommittee meeting minutes.

The committee consists of 22 members. Fifty percent represent minority groups. Ex-officio members include top administrators from the Department of Health and Human Resources, Office of Family Security, Office of Human Services, Office of Hospitals, Office of Mental Health, Office of Mental Retardation, Director of Charity Hospitals, and the Assistant Superintendent of Special Education - State Department of Education. Committee membership also includes representatives of consumer and provider groups, State employees, and fiscal agents. Consumer categories represented include: legislators, recipients, labor unions, association for retarded citizens, civil rights, mayors. Provider categories include dentists, physicians, optometrists, the health care association, the hospital association, and a medical appliances representative. An important role played by the members of these various groups is to actively participate on subcommittees. The subcommittee groups of this Medical Care Advisory Committee include:

Provider Relations
Recipient Relations
Long Term Care
Fiscal Operation
EPSDT
Adult Services
Medically Needy
Pharmacy
By-Laws

Attendance at the bi-monthly Medical Care Advisory Committee meeting averages approximately 40 people. This includes members, resource speakers, guests, and State staff, as well as those participants in subcommittee meetings.

The committee has developed a comprehensive set of by-laws to comply with Federal regulations. Every attempt is made to adhere to the policies set forth in the articles contained in these by-laws.

RESULTS: The Louisiana Title XIX program has an excellent relationship with the Medical Care Advisory Committee. The agency fully utilizes this group as a resource for program and management improvement.

The committee and subcommittees are encouraged by the Title XIX program to make recommendations and a review of past meeting minutes indicates that these recommendations are considered and implemented in many situations.

Improved management has resulted through greater participation by management oriented entities on subcommittees of the Medical Advisory Committee. Subcommittee members include: Vice President, Pan American Life Insurance Company; Vice President, Louisiana Blue Cross/Blue Shield; Manager of Provider Relations, EDS Federal Corporation. These subcommittee members bring a valuable knowledge and perspective to the program since they serve as the Medicare carrier, intermediary, and Medicaid fiscal agent. They also are participating in other facets of HCFA programs such as paperless billing and Medicare crossover which impinge on HCFA's attempts to integreate portions of the Medicaid and Medicare programs. Program savings appear to be significant; however, the actual fiscal impact is difficult to calculate. It is our belief that considerable saving will result from the expertise provided by subcommittee members in the area of claims processing, one of the largest cost items in the Louisiana budget. Utilization of knowledgeable claims processing members is only one program area that the Medical Care Advisory Committee and subcommittees used to assist the State to improve program management and administration.

The State has benefited from the submittal of many policy recommendations which have been adopted and implemented.

FOR FURTHER INFORMATION CONTACT:

Bonnie Smith, Director
Medical Assistance Program
Administration
Office of Family Security
Post Office Box 44065
Baton Rouge, Louisiana 70804
(504) 342-3891

LOUISIANA STATE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAL CARE ADVISORY COMMITTEE

BYLAWS

The purpose of the State Medical Care Advisory Committee of the Office of the Secretary of Louisiana Department of Health and Human Resources is established to improve and maintain the quality of the State's Medical Assistance Program by:

(1) Contributing specialized knowledge and experience to be added to that available within the Medical Assistance Program, and

(2) Providing a two-way channel of communication with the individuals, organizations and institutions in the community that, with DHHR, provide and/or pay for medical care and services.

This shall not be a policy making board. The Committee's functions are advisory only.

The Medical Care Advisory Committee is established in accordance with Section 246.10, Title 45 (Chapter II), of the Code of Federal Regulations which was published in the Federal Register on February 27, 1971, and program policies promulgated for the guidance of DHHR.

ARTICLE I

Membership

Section 1. The Committee shall be comprised of a minimum of twenty-one (21) active members, including five (5) consultant state legislators (two (2) senators and three (3) representatives) who are appointed by the Secretary of DHHR and ten (10) ex officio members. This number shall be exceeded should the Secretary choose to appoint additional members.

Section 2. The State Medical Care Advisory Committee is to be interdisciplinary and will include representatives of the public and of the consumer. It is expected to be a knowledgeable group, dedicated to the delivery of high quality, purposefully planned medical services to the poor. The Medical Care Advisory Committee will include:

(1) Board certified physicians and other representatives of the health professions who are familiar with the medical needs of low income population groups and with the resources available and required for their care.

(2) Members of consumers' groups, including Title XIX recipients, and consumer organizations.

(3) The director of the public welfare department or of the public health department, whichever does not head the Single State Agency for the Title XIX plan.

The membership of the Committee shall consist of fifty-one percent (51%) consumers and consumer advocates with the remaining number being providers. In an effort to assure a statewide representation, each planning region shall be represented on the Committee by at least one member. Efforts will be made to insure representation of minorities, women and persons with income below the poverty level. In the case of minorities, the membership should contain a collective ratio closely approximating that reflected in the total state population. To help assure representativeness of membership the Secretary's Office will be informed of any disproportions in the above mentioned categories each time that new appointments must be made.

Ex officio members shall consist of the DHHR Secretary and Assistant Secretaries of DHHR Office as follows:

Assistant Secretary, Office of Family Security
Assistant Secretary, Office of Human Development
Assistant Secretary, Office of Hospitals
Assistant Secretary, Office of Mental Health and Substance Abuse
Assistant Secretary, Office of Mental Retardation
Assistant Secretary, Office of Charity Hospital at New Orleans
Assistant Secretary, Office of Licensing and Regulations
Assistant Secretary, Office of Health Services and Environmental Quality, and
Also, the Assistant Superintendent of Special Education, State Department of Education

Section 3. In the event that the total membership should fall below the minimum of twenty-one (21) persons, the Chairman of the Committee shall submit to the Secretary of DHHR a list of one or more names for appointment to the Committee.

The Committee shall not recommend to the Secretary for membership on the Committee employees from the Single State Agency or any other authority by which the Committee is mandated.

Section 4. Members shall be appointed on a rotating basis for three (3) year periods with overlapping terms for continuity. Initially, appointments shall be made for one, two and three year terms to provide for planned rotation.

Section 5. A member shall be removed from the Committee for any one of the following causes:

(1) Absence from two consecutive meetings without contacting the Chairman or Committee Secretary with a satisfactory explanation.

(2) Receipt of a letter of resignation from the member.

(3) Moving out of the state.

A letter of removal from the Secretary of DHHR to the member is required in order for the member to be considered officially dropped from committee membership.

It will be the Chairman's responsibility to contact the member who has two (2) consecutive absences. The Chairman may delegate someone to contact the member.

Terminations shall be filled by the Secretary of DHHR within thirty (30) days of the date a vacancy occurs. An alternate member from the same membership category shall be considered for active membership before consideration of a new nomination for membership.

ARTICLE II

Officers

Section 1. There shall be two officers of the Committee. These shall be designated as the Chairman and Vice-Chairman.

The Chairman shall be appointed by the Secretary of DHHR.

The Vice-Chairman shall be nominated from the floor and elected by a majority vote of the Committee.

A full time member of the Department of Health and Human Resources acts as Committee Secretary, but has no vote.

Section 2. The Chairman's duties are to call all meetings of the Committee and to preside at all regular and special meetings of the Committee. He shall present committee recommendations to the Secretary of DHHR through the Office of Family Security, Medical Assistance Program, and prepare an annual report on the Committee's activities. He shall appoint such subcommittees deemed necessary to the smooth operation of the body and shall appoint the chairpersons of the several standing subcommittees.

Section 3. The Vice-Chairman shall exercise all powers of the Chairman in the event of the absence of or inability of the Chairman to serve and shall perform such other duties as the Chairman may assign to him.

Section 4. Membership on the Committee is the single qualification required to hold any office.

Section 5. The tenure of all offices and membership on the executive subcommittee shall be one (1) year with the provision that any officer or member of the executive subcommittee may succeed himself in office.

ARTICLE III

Standing Subcommittees

Section 1. The Committee shall function with the following standing subcommittees:

(1) Subcommittee on Fiscal Operation of Title XIX

(2) Subcommittee on Provider Relations

(3) Subcommittee on Recipient Relations

(4) Subcommittee on Long Term Care

(5) Subcommittee on Early Periodic, Screening, Diagnosis, and Treatment (EPSDT)

(6) Executive

Section 2. The number of members of all standing subcommittees, except the Executive Committee, shall be left to the discretion of the subcommittee chairman.

Nominations for membership to all subcommittees, except the Executive Subcommittee, shall be submitted to the Secretary of DHHR with the approval of the chairman of the Medical Care Advisory Committee and the Office of Family Security Medical Assistance Program. Appointment to subcommittees will be made by the Secretary of DHHR.

Section 3. The Executive Subcommittee shall be comprised of the chairman, vice-chairman, and the secretary, plus at least two appointed members to be named by the chairman.

Section 4. The functions of the several standing subcommittees, except the Executive Subcommittee, shall be arrived at by the respective chairman and the Executive Subcommittee.

Section 5. Functions of the Executive Subcommittee shall include:

(1) Preparation for regular meetings

(2) Motivation for committee action

(3) Consultation with the State Agency

ARTICLE IV

Voting

Section 1. Active members shall carry an equal vote, excepting ex officio members. Voting shall follow the majority rule method. A quorum shall be established by the presence of a simple majority. Active members of the Committee, if they wish, may designate a proxy with the consent of the chairman. Representation of members shall be counted for all purposes.

ARTICLE V

Meetings

Section 1. The Committee shall meet quarterly or as prescribed by the Secretary of DHHR in the first meeting of the Committee with the chairman reserving the right to call additional meetings as necessary. Subcommittee meetings shall be scheduled as needed by the chairman of each subcommittee.

ARTICLE VI

Committee Support

Section 1. The Assistant Secretary of Office of Family Security shall be

delegated to represent the DHHR Secretary in all functions of the committee and conversely, shall represent the Committee with its recommendations to the Secretary.

Section 2. The Office of Family Security, Medical Assistance Program, shall offer support to the Committee as follows:

(1) Initial orientation.

(2) Research and final preparation of documents generated by Committee.

(3) Preparation of Committee recommendations for presentation to the Secretary.

(4) Notification of meetings of the Committee and subcommittees.

Section 3. The agenda shall incorporate all matters delegated for review by subcommittees. However, any matters of policy may be presented to the Committee for consideration.

The agenda shall be prepared by the Chairman, with assistance of staff, from issues presented to the Chairman by the Secretary, DHEW Regional Office, committee staff, program directors, individual committee members, and consumer groups through a committee member.

The agenda shall be prioritized utilizing the following criteria:

(1) Urgency of issue at hand

(2) Time allotted for meeting

(3) Capability of Committee to make recommendations on a specific problem

(4) Whether members have sufficient knowledge of facts and background information to review the issue presented

Each issue presented for consideration by the Committee shall be accompanied by adequate background information.

The agenda and informational materials shall be forwarded to committee members one week in advance of scheduled or called meetings.

Only agenda items will be considered unless non-agenda item is proposed by a three-fourth (3/4) vote of those members present.

Section 4. At the end of the third quarter of each fiscal year, the Committee shall prepare and present for public review, a report of its activities and an assessment of the quality/quantity of medical services available to Title XIX eligibles in Louisiana.

Section 5. As provided under Section 246.10 of Chapter 45 of the Code of Federal Regulations, members' expenses incurred in connection with committee or subcommittee meeting attendance shall be fully reimbursable; however, normal state reimbursements procedure and policies will apply, to the extent possible.

ARTICLE VII

Rules of Order

Section 1. The rules contained in Robert's Revised Rules of Order shall govern the Committee in cases to which they are applicable, and in which they are not inconsistent with the bylaws of this Committee.

Section 2. These bylaws may be amended by a majority of voting members. The chairman shall provide a copy of porposed amendments to each committee member at least two weeks prior to voting on said amendment.

Approved: 3/ /80

TEXAS

THIRD PARTY RESOURCE PROJECT

PRACTICE: Cost avoidance and recovery through identification and utilization of third party resources.

PURPOSE: During the last half of 1978 concern was expressed that third party resources of recipients were not being used to reduce Medicaid costs. Systems in most other states would flag certain cases based on trauma codes and other information present on the eligibility file. The cost of verifying liability of other insurance companies combined with the lack of coverage thought to be available to Medicaid recipients resulted in very little effort to pursue dollars to avoid or replace Medicaid costs.

Because of the possibility of saving Medicaid funds, the State of Texas conducted a pilot project in the Austin region (Texas is divided into regions) in early 1979 to determine if recipients had third party resources in sufficient amount to justify a system to collect, detect and/or cost avoid expenditures on behalf of the affected group. The outcome of the project indicated a minimum annual estimate of $5,500,000 in savings from private health carriers and that 3% or 18,000 of the Texas Medicaid population had coverage. The cost benefit ratio was estimated to be 1 to 5.

During the spring 1979 legislative session, a law was passed that automatically assigns the recipient's rights to insurance coverage to the State. It also prohibits Medicaid exclusion clauses in insurance policies.

Based on the favorable results of the pilot project, the decision was made to identify all recipients with third party resources and obtain voluntary assignment.

DESCRIPTION: Questionnaires were mailed to all Medicaid recipients during June, July and August 1979. Over 80% of the recipients responded to the mail out and subsequent follow ups. Approximately 6% of the recipients reported some form of commercial health insurance. Purging the files of life insurance, burial, indemnity and specific illness policies lowered the figure to 3%.

With the cooperation of the Texas Employee's Retirement System, the Medicaid file was matched against the State Group Insurance file. 1,235 clients were identified as employed by the State and covered by State health insurance. Adding the covered dependents of these clients increased the number identified to 2,000.

The TPR system is maintained through updates to the third party resource information each time an eligibility worker reviews recipient eligibility. Information is gathered on insurance provided by an absent parent, work related coverage, coverage purchased by the recipient and any other insurance available to the recipient. Information collected includes policy number, company name, address and type of coverage. The eligibility file is coded with a coverage indicator and claims are screened against this. When private insurance appears to be applicable, claims are returned to the provider with information about the coverage and instructions to file with the other company first. After the private carrier makes a payment, the provider resubmits the claim to Medicaid. On cases such as SSI where the eligibility worker does not see the recipient, the State mails a questionnaire to the recipient annually to update the files.

Procedures to be followed in recovering funds after payment has been made and in the case of tort claims are currently under revision. This is somewhat complicated by the fact that some claims are paid under the insuring arrangement and some are paid directly by the State.

RESULTS: In a state the size of Texas, it is expensive to collect the information needed to have an effective third party recovery system. However, it has been proven that the effort saves a great deal more than the cost.

During August 1979, the first full month of operation of the system, approximately $835,000 was cost avoided. Based upon experience, it appears that approximately $12,000,000 will be saved during the first full year of operation rather than the estimated $5,500,000. The cost ratio is also expected to increase from 1 to 5 to about 1 to 10. Negotiations with National Heritage Insurance Company in the summer of 1979 resulted in an agreed reduction of $9,000,000 in FY 80 premiums to allow for these savings.

Table I shows the response to the mail out survey by program. Each of the program areas responded differently. Of particular note is the fact that MAO's (Medical Assistance Only) had private insurance at almost 4 times the rate of AFDC clients.

As of September 1, 1979, after three months of conducting the survey, 76.54% of the clients responded to the mail out. Of this percentage, 4.4% were placed on TPR review. Another 1.7% indicated that they had private insurance but did not submit enough information to cost avoid.

Table II shows the amount of money which was collected from the provider or was documented on the claim form as payment made by the private health insurance.

A special research project was conducted to determine what happens to claims after they are denied. Claims denied because of TPR from January 1, 1979 through February 19, 1979 were selected for detailed analysis. During this time, NHIC received 698 claims totaling $749,847 for 419 recipients on TPR review. Table III reflects the findings of this research project. 91.7% of all claims submitted were returned to the provider for refiling with the private insurance company. The remaining 8.3% represents claims which were initially submitted correctly by the provider showing coordination of the private insurance carrier.

Providers are given an unlimited time to refile with the private carrier. Table III tracks the monthly rate which claims are refiled with Medicaid by the provider after TPR rejection. The bar "NHIC denied this amount" decreased generally at the same rate as the bar "Other Insurance Paid" increased. However, the rate of change is not exact; the difference in the rate of decrease/increase represents the portion of the Medicaid allowable not covered by the private insurance policy.

Table III emphasized three important characteristics of the present cost avoidance process as it impacts the provider community. (1) Previous to the TPR program, only 8.3% of the claims with TPR available were submitted to Medicaid showing prior coordination with the private insurance carrier. (2) Of the claims rejected to the provider, approximately 66% were never resubmitted to Medicaid for payment. (3) Based upon the claims which were returned to Medicaid, the private insurance generally paid more than the Medicaid allowable.

A final note in relation to reporting TPR savings: Table II represents only documented TPR savings. It does not represent saving on claims which are denied and then never resubmitted by the provider to Medicaid for payment. As the experience of the Table III project increases, factors will be developed that will be utilized to increase the accuracy of TPR cost savings. This refinement in reporting is expected to double the "Total Private Insurance" figure which is presently reported on Table II.

With the cooperation of the Texas Employee's Retirement System (ERS), the Medicaid file was matched against the State Group Insurance file. Table IV represents the characteristics of the covered clients according to coverage and type plan.

Discussions are presently underway with the Employee's Retirement System to recover approximately $200,000 from Metropolitan and the Title XIX providers.

FOR FURTHER INFORMATION CONTACT: Arnold G. Ashburn, Ph.D.
Assistant Commissioner
Purchased Health Services
Texas Department of Human Resources
512-458-1335

TABLE 1

TPR JUNE 1, 1979 MAILOUT REPORT

ENT	TYPE PROGRAM							
PONSE	AFDC		MAO		SSI		ALL PROGRAMS	
	#	%	#	%	#	%	#	
RESPONSE	80,759	26.33	18,002	31.14	38,080	14.23	136,856	21.67
INSURANCE	207,998	67.81	31,935	55.77	205,340	76.73	445,279	70.50
DELIVERED?	8,662	2.82	839	1.57	1,774	.66	11,277	1.79
S INSURANCE MPLETE	5,081	1.66	5,413	9.55	17,175	6.42	27,669	4.38
S INSURANCE COMPLETE	4,230	1.38	1,069	1.87	5,231	1.96	10,530	1.66
S INSURANCE TAL	9,311	3.04	6,482	11.42	22,406	8.38	38,199	6.04
TAL	306,730	100	57,258	100	267,600	100	631,611	100

esults as of September 1, 1979

Table II

TPR Cost Savings
January - August 1979

TYPE	No. of Claims	Dollars
1. Liability/Accident Settlements	94	$ 80,860.29
2. Cash Refunds from Providers	Not Available	515,602.41
3. Payments by Private Health Insurance	8,624	2,478,839.45
TOTAL PRIVATE INSURANCE		$ 3,075,302.15

TABLE III

TPR PILOT PROJECT FOLLOW-UP - REGION 5

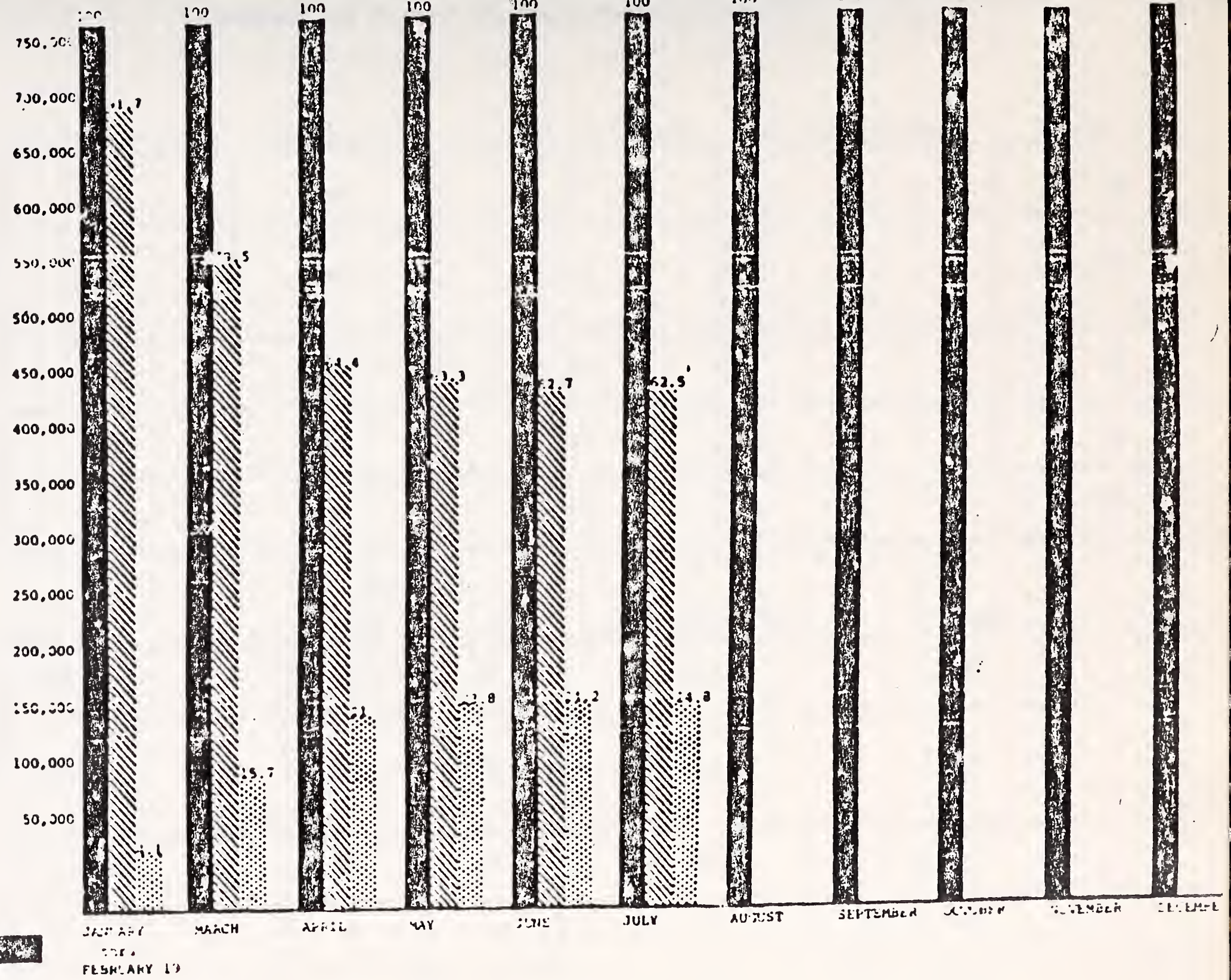


TABLE IV

CHARACTERISTICS OF STATE EMPLOYEES COVERED BY MEDICAID

	COVERAGE				
CATEGORY	EMPLOYEE AND SPOUSE	EMPLOYEE ONLY	EMPLOYEE AND CHILDREN	EMPLOYEE AND FAMILY	TOTALS
AGED	1%	8%	0%	0%	9%
AID TO FAMILIES WITH DEPENDENT CHILDREN	1%	31%	47%	2%	81%
BLIND	0%	1%	0%	0%	1%
DISABLED	1%	6%	1%	1%	9%
TOTALS	3%	46%	48%	3%	100%

TYPE PLAN

	HIGH	MID	BASE	HMO	RETIRED (OVER 65)	TOTALS
AGED	0%	0%	0%	0%	9%	9%
AID TO FAMILIES WITH DEPENDENT CHILDREN	26%	18%	37%	0%	0%	81%
BLIND	1%	0%	0%	0%	0%	1%
DISABLED	2%	1%	5%	1%	0%	9%
TOTALS	29%	19%	42%	1%	9%	100%

Texas Department of Human Resources

John H. Reagan Building, Austin, Texas 78701

October 22, 1979

Mr. Bill E. McCutchen, Director
Division of Program Operations
Health Care Financing Administration
Department of Health, Education and Welfare
1200 Main Tower Building
Dallas, Texas 75202

Dear Mr. McCutchen:

This is in response to your August 10, 1979, letter regarding activities in the area of third party resources (TPR). The summary of activities as outlined correctly identifies actions being taken by this Agency and your administration in relation to third party resources. The following is an update to that activity summary.

As indicated in your letter, during June, July and August 1979, questionnaires were mailed to all Medicaid recipients statewide. The response to this mailout and subsequent follow-up mailouts was unexpectedly high for this type of survey operation. Approximately 80% of all recipients completed and returned the questionnaire. Early statistical data indicates that 6.04% of the recipients in Texas have some form of commercial health insurance. This figure is significant in that the Department had anticipated only about 3.5% of its recipients having any form of valid third party health resources.

Department staff in the areas of Aid to Families with Dependent Children (AFDC) and Medical Assistance Only (MAO) are developing the procedures for updating the third party resource data base beginning January 1, 1980. As you indicated in your letter, this procedure will cause the TPR data base to become a part of the eligibility subsystem within the SAVERR System. With regard to the Supplemental Security Income (SSI) population, periodic mailouts will be used to maintain accurate data on this group of recipients. This Department is in the process of cancelling its contract with the Social Security Administration for the private insurance indicator. Since this information has proven to be in error a majority of the time and cannot be used in a cost-avoidance mode of operation, the continued expenditure of funds for its purchase was considered inappropriate.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE -

AUG 10 1979

Mr. Jerome Chapman
Commissioner
Department of Human Resources
John H. Reagan Building
Austin, Texas 78701

Dear Mr. Chapman:

During the past 14 months a lot of activity has occurred in the area of third party resources in Texas. In reviewing reports of all that has transpired, I note there may be room for confusion over what has been done by whom in our office and what is the next action, if any. The purpose of this letter is to summarize the activities of the several components of the Health Care Financing Administration during the time period and to present our understanding of actions underway to correct problems and weaknesses in the system.

An assessment of third party resources activity at National Heritage Insurance Company occurred May 16-18, 1978 as part of an assessment review. A draft of the findings was delivered June 23, 1978 and a final report was sent on August 11, 1978. Shortly thereafter a State agency task force on third party resources was organized and a pilot project was started in the Austin region to determine the amount of third party resources available and the costs of securing the information.

On February 12-16, 1979 a second part of the State assessment was conducted. At this time the State's system for utilizing third party resources in the areas of long term care, drugs, EPSDT, dental, adult dentures, hearing aids and transportation was reviewed. A draft report was sent on April 10, 1979. On April 24, 1979 you submitted additional information regarding actions taken by the State and outlined progress made.

During February and March several components of HCFA were being asked to become more involved in the pursuit of third party resources. In an effort to coordinate this activity we wrote to you on March 5 requesting a meeting between your staff and HCFA Quality Control, Financial Management, State Assessments, and Program staff. This meeting

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

was held on March 13. Your staff reported on the pilot project and told us of plans to go statewide and collect the necessary third party information. Since many of the problems discussed during this meeting had already been reported and your staff was actively pursuing resolutions, we made no detailed report.

An amendment to the NHIC contract to collect third party resource information and develop a system to maintain the information was prepared and subsequently approved by HCFA. Around June 1 questionnaires were mailed to about 600,000 recipients. As new eligibles came on the rolls they were mailed the questionnaire or the information was supplied by the local eligibility worker. Response to the effort, we understand, has been good with over 400,000 responses received in less than two months. About 3½% of the respondents have valid third party health resources.

We are told that the new system will become a part of the eligibility subsystem within the SAVERR system. All claims processing units will have access to the information and all expenditures on behalf of the recipient will be checked against the file. In addition we understand work on coordinating tort liability claims is progressing satisfactorily.

We appreciate very much your cooperation in sharing your plans and progress reports. We would like to continue to follow the progress of this effort and will be interested in receiving information on cost of the effort, recoveries (including Medicare) and avoidance of expenditures due to third party resources. We plan to review the quality control findings and work with you to take corrective action if problems are found.

Unless you feel the need to do so, it is not necessary to respond to this summary. However, we would appreciate a report around October 1, 1979, or as soon thereafter as practicable, of the status of the effort currently underway.

Thanks again for your cooperation. Any time we may be of assistance, please call.

Sincerely,

Bill E. McCutchen, Director
Division of Program Operations

cc: Emmett W. Greif, M.D.

THIRD PARTY RESOURCES
October 3, 1979

A Brief for Congressman J. J. "Jake" Pickle

I. Previous Predictions

The Central Texas pilot project conducted in early 1979 indicated the following:

- a minimum estimate of $5,500,000 savings from private health carriers
- 18,000 or 3% of the Texas Medicaid population
- Cost benefit ratio was estimated to be approximately 1 to 5

II. Current Status

The Central Texas pilot project was implemented on a statewide basis on June 1, 1979. Projections related to the number of clients with private coverage were verified or exceeded.

- Approximately $835,000 was cost avoided in the first full month of operation, August 1979.
- 38,000 or 6% of the clients reported private coverage. Purging of the files for life insurance, burial, indemnity, and specific illness policies is currently underway and is expected to lower this figure to the predicted 3% level.
- The predicted 1 to 5 cost benefit ratio will be exceeded.

III. Future Savings

Based upon past experiences, it appears that approximately $10,000,000 will be saved rather than $5,500,000 in the first full year of operation. The cost benefits ratio is also expected to increase; a 1 to 7 savings ratio, rather than a 1 to 5, is expected. National Heritage Insurance Company agreed to a reduction of $9,000,000 in the 1980 premiums to allow for these savings.

IV. Effectiveness of System

A recent match between the Medicaid and the Texas Employee's Group Insurance files was conducted. In comparing this information against the records established through the mailout and those gathered by the caseworkers, the effectiveness of the system was measured. Based upon these preliminary findings, it appears that the current system for gathering third party resource information is functioning at a 97% rate of efficiency.

V. Plans

Rather than collect third party resource data through a mailout, beginning January 1, 1980, caseworkers will gather the data during the eligibility process (except for SSI cases, which will continue to be handled through mailouts). Also, plans are underway for establishing a postpayment collection unit. This unit will pursue collection in cases where the third party's liability is identified after a Medicaid payment.

Summary of Third Party Resource Statistics

ıe following tables present detailed figures on the status of the Third Party :source Program in Purchased Health Services. Significant conclusions and obser- ıtions on these tables are noted below:

ıble I - "TPR June 1, 1979, Mailout Report"

ıis table reflects the effectiveness of the June 1, 1979, TPR survey of all :dicaid clients. Each of the three program areas responded differently. Of ırticular interest is the observation that MAO's have private health insurance at ɔur times their AFDC counterparts.

ı of September 1, 1979, after three months of conducting the survey, 78.33 of ıe clients responded to the mailout. Of this percentage, 27,669 clients (4.38%) :re placed on TPR review. Another 10,530 clients (1.66) indicated that they had rivate health insurance but did not submit sufficient data to NHIC to cost avoid. ıis group of "Yes Insurance-Incomplete" is the target group of the telephone nquiry unit and will be refined in the coming months.

.04% of the total client population is believed to have some form of private health nsurance. This figure is very close to earlier predictions; a cost savings in the oming fiscal year of approximately 10 million dollars appears to be a very realistic igure.

able II - "TPR Cost Savings, January - August 1979"

here are two sets of figures which can be reported in the area of TPR Savings;) actual dollars which are recovered or reported as collected, and 2) dollars which re cost avoided, that are only documented in the fact that the claim was not paid ɣ Medicaid but returned to the provider for refiling with the private insurance :arrier. This latter situation is addressed in Table III.

'able II represents the sums of money which are either collected from the provider ɔr which are documented on the claim form as payment made by the private carrier ɔr Medicare. Table II's figures will be used in the future in measuring the success ɔf the June 1, 1979, mailout.

Table III - "TPR Pilot Project Follow-up-Region 06"

NHIC's focus is upon cost avoidance. Claims are screened against the TPR data base, and when the private insurance policy appears to be applicable, returned to the provider for refiling with the private carrier. After the private carrier makes a payment, the provider resubmits the claim to Medicaid.

Since September 1, 1978, the amount which has been cost avoided on a monthly basis has increased from $260,671 to $715,610. The primary question of concern in this area of increased activity is "What happens to the claim after it is denied?" In order to answer this question, a special research project was conducted. Claims denied because of TPR for January 1, 1979, through February 19, 1979, were selected for detailed analysis. During this time, NHIC received 698 claims totaling $749,847 for 419 recipients on TPR review.

ble III reflects the findings of this research project. 91.7% of all claims bmitted were denied back to the provider for refiling with the private insurance mpany. The remaining 8.3% represents claims which were initially submitted rrectly by the provider showing coordination of the private insurance carrier.

roviders are given an unlimited time to refile with the private carrier. Table II tracks the monthly rate which claims are refiled with Medicaid by the provider fter TPR rejection. The bar "NHIC denied this amount" decreased generally at he same rate the bar "Other Insurance Paid" increased. However, the rate of hange is not exact; the difference in the rate of decrease/increase represents he portion of the Medicaid allowable not covered by the private insurance policy.

able III emphasized three important characteristics of the present cost avoidance rocess as it impacts the provider community. (1) Previous to the TPR program, nly 8.3% of the claims with TPR available were submitted to Medicaid showing prior oordination of the private insurance carrier. (2) Of the claims rejected back to he provider, approximately 66% were never resubmitted back to Medicaid for payment. 3) Based upon the claims which were returned to Medicaid, the private insurance enerally paid more than the Medicaid allowable.

final note in relation to reporting TPR savings, Table II represents only documented PR savings. It does not represent saving on claims which are denied and then never esubmitted by the provider to Medicaid for payment. As the experience of the Table II project increases in time, factors will be developed that will be utilized in ncreasing of accuracy of TPR cost savings. This refinement in reporting is expecte o double the "Total Private Insurance" figure which is presently reported on Table I.

Table IV - "Characteristics of State Employees Covered by Medicaid"

With the cooperation of the Texas Employee's Retirement System (ERS), the Medicaid file was matched against the State Group Insurance file. 1,235 clients were identified as employed by the State and covered by Metropolitan Insurance. By adding the covered dependents, the number identified in this project increased to over 2,000.

This information was passed along to NHIC for cost avoidance and validation purposes. Table IV represents the characteristics of this group of clients according to coverage and type plan.

Discussions are presently underway with ERS in recovering approximately $200,000 from Metropolitan and the Title XIX providers.

TABLE 1

TPR JUNE 1, 1979 MAILOUT REPORT

ENT	TYPE PROGRAM							
PONSE	AFDC		MAO		SSI		ALL PROGRAMS	
	#	%	#	%	#	%	#	
RESPONSE	80,759	26.33	18,002	31.14	38,080	14.23	136,856	21.67
INSURANCE	207,998	67.81	31,935	55.77	205,340	76.73	445,279	70.50
DELIVERED?	8,662	2.82	839	1.57	1,774	.66	11,277	1.79
INSURANCE MPLETE	5,081	1.66	5,413	9.55	17,175	6.42	27,669	4.38
S INSURANCE COMPLETE	4,230	1.38	1,069	1.87	5,231	1.96	10,530	1.66
S INSURANCE TAL	9,311	3.04	6,482	11.42	22,406	8.38	38,199	6.04
TAL	306,730	100	57,258	100	267,600	100	631,611	100

esults as of September 1, 1979

Table II

TPR Cost Savings
January - August 1979

TYPE	No. of Claims	Dollars
1. Liability/Accident Settlements	94	$ 80,860.29
2. Cash Refunds from Providers	Not Available	515,602.41
3. Payments by Private Health Insurance	8,624	2,478,839.45
TOTAL PRIVATE INSURANCE		$ 3,075,302.15

TABLE III

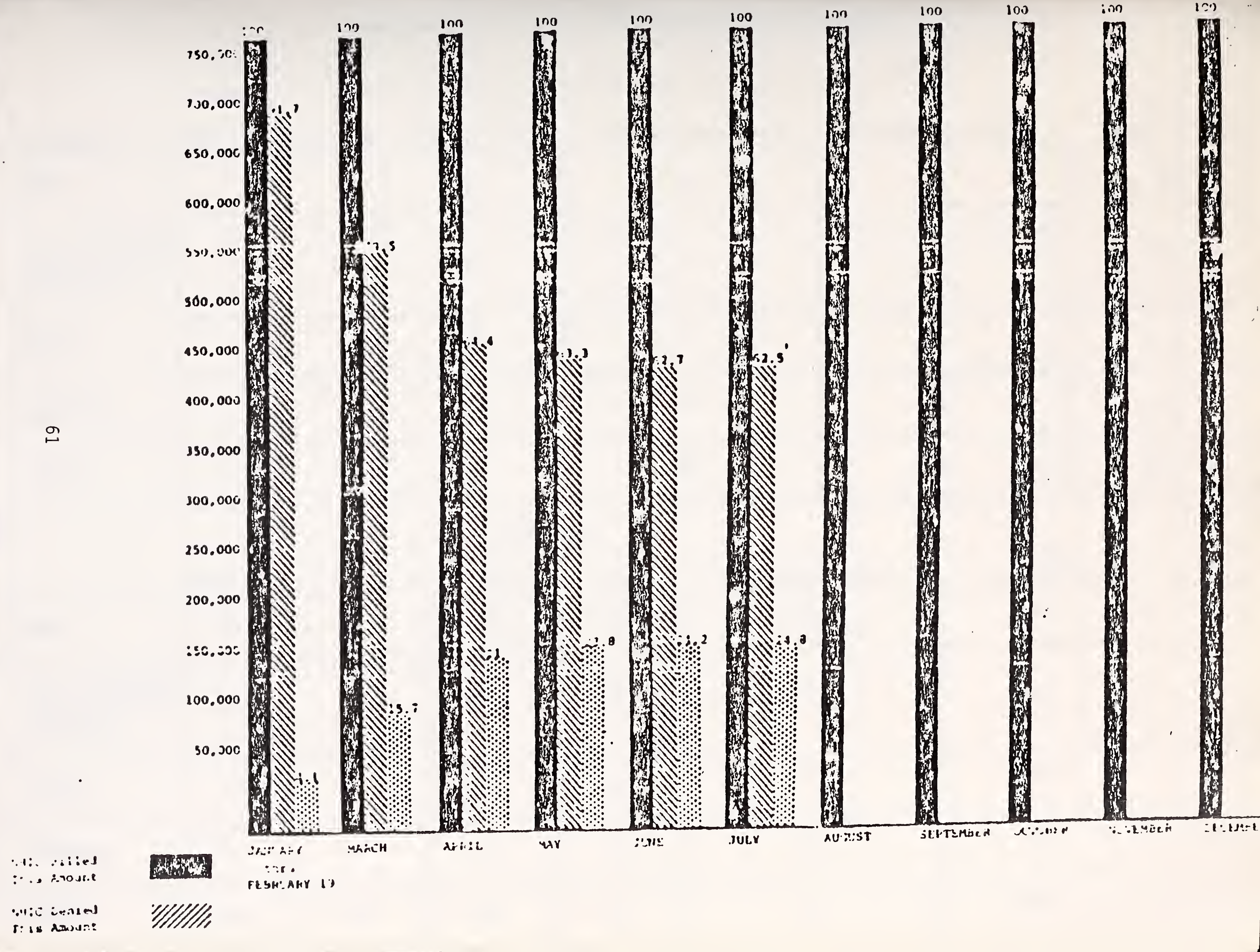

100
750,000
650,000
600,000
500,000
450,000
400,000
350,000
300,000
250,000
200,000
100,000
50,000
MARCH
MAY
JULY
SEPTEMBER
FEBRUARY

TABLE IV

CHARACTERISTICS OF STATE EMPLOYEES COVERED BY MEDICAID

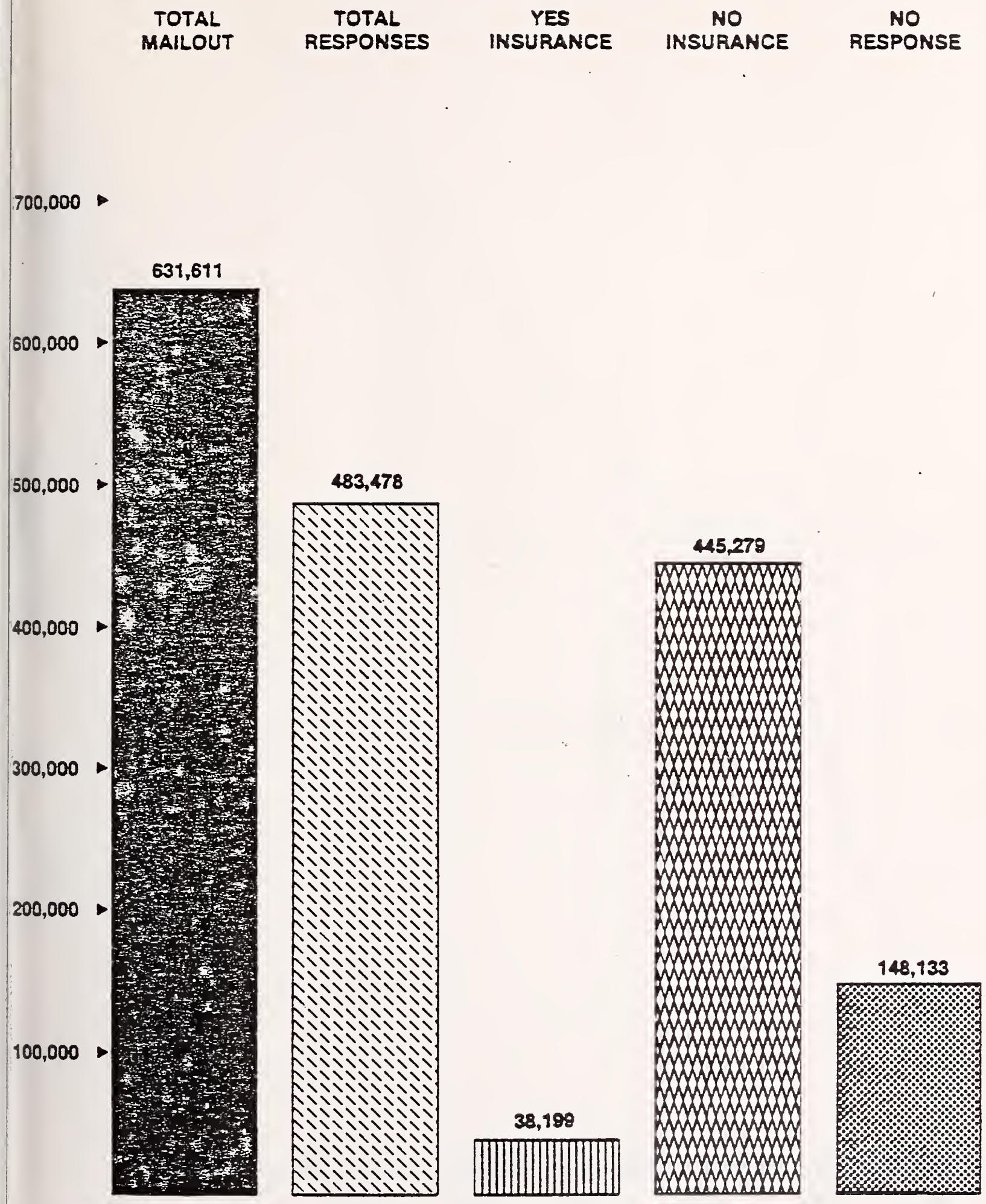
CATEGORY	COVERAGE: EMPLOYEE AND SPOUSE	EMPLOYEE ONLY	EMPLOYEE AND CHILDREN	EMPLOYEE AND FAMILY	TOTALS
AGED	1%	8%	0%	0%	9%
AID TO FAMILIES WITH DEPENDENT CHILDREN	1%	31%	47%	2%	81%
BLIND	0%	1%	0%	0%	1%
DISABLED	1%	6%	1%	1%	9%
TOTALS	3%	46%	48%	3%	100%

	TYPE PLAN: HIGH	MID	BASE	IMO	RETIRED (OVER 65)	TOTALS
AGED	0%	0%	0%	0%	9%	9%
AID TO FAMILIES WITH DEPENDENT CHILDREN	26%	18%	37%	0%	0%	81%
BLIND	1%	0%	0%	0%	0%	1%
DISABLED	2%	1%	5%	1%	0%	9%
TOTALS	29%	19%	42%	1%	9%	100%

TPR SPECIAL PROJECT COST ANALYSIS

- **SPECIAL PROJECT EXPENSE** — **$572,431.00**
- **COST/RESPONSE** — **$1.11**
- **COST/YES RESPONSE** — **$14.75**
- **PROJECT COST/BENEFIT RATIO** — **1:6.5**

CLIENT CONTACT AND RESPONSE INFORMATION



SAVINGS

ACTUAL

PROJECTED

8,000,000

7,000,000

6,000,000

5,000,000

4,000,000

3,000,000

2,000,000

1,000,000

0

COST AVOIDED SAVINGS

DIRECT SAVINGS

MARCH '79 APRIL MAY JUNE JULY AUGUST SEPTEMBER OCTOBER NOVEMBER DECEMBER JANUARY FEBRUARY '80

ARKANSAS

VISUAL CARE PROGRAM

PRACTICE: Use of competitive bids to secure a statewide contract with an optical company as supplier of eyeglasses, contact lenses and repairs of eyeglasses.

PURPOSE: (1) Maximum efficiency in administration of the visual care program, (2) Cost effectiveness.

DESCRIPTION: Arkansas has chosen to provide eyeglasses and contact lenses to Medicaid eligibles through a single supplier. The supplier is selected through a competitive bid process administered through the State Purchasing Office.

Currently bids are sought for one-year periods but the State plans to increase the contract period to two years at the request for bids in 1981.

The bid request contains 138 line items which must be bid upon. Line items include lenses, frames, glass cases and repairs. Further specifications include requirements for provision of a toll-free inquiry line, reporting procedures, quality assurance, time frames for providing services, etc.

Provision of eyeglasses to individual Medicaid recipients is accomplished through the following procedure: Participating visual care providers (ophthalmologists and optometrists) are provided with displays of sample frames of all available styles. After the patient is examined and chooses the frame style, the provider forwards the prescription to the State agency. All orders are sent directly to the supplier from the State agency and then are sent directly from the supplier to the prescribing optometrist or ophthalmologist for fitting. The visual care supplier is then reimbursed directly by the State just as other individual providers. The supplier submits individual claims for payment on forms prescribed by the State.

Approximately 20,000 visual prescriptions were processed under the program in 1980, for program costs of $404,000.

A copy of the latest request for bids is attached.

RESULTS: While the State has no basis for determining actual savings (the visual care program has always been administered through a bid process), the State's visual care program consultants consistently maintain that the State is paying considerably less for visual supplies than it would pay if reimbursement were on a usual-and-customary basis. In addition, the State

feels there is less opportunity for claims processing errors since the system is programmed with unique reimbursement codes for each line item. This eliminates possible pricing errors that could result from multiple providers with different charges.

FOR FURTHER INFORMATION CONTACT:

Mike McKenzie
Medical Services Division
Arkansas Social Services
Department of Human Services
Post Office Box 1437
Little Rock, Arkansas 72203
(501) 371-2388

PURCHASE REQUEST 80-126A

TO:
PURCHASING DIVISION
DEPT. OF FINANCE & ADMINISTRATION
P. O. BOX 2940
LITTLE ROCK, ARKANSAS

FROM:
SOCIAL SERVICES DIVISION OF
ARKANSAS SOCIAL & REHABILITATIVE SERVICES
PURCHASING DIVISION
P. O. BOX 1437
LITTLE ROCK, ARKANSAS 72203

te May 5, 1980 Page 1 of 1

antities Listed are Firm ☐ or Estimated ☐ F.O.B. _____

rm: From _____ to _____ Delivery on or before _____

TRANS CODE	APPROP CODE	ACTIVITY CODE	CHAR CODE	DOC NO.	AMOUNT	STATE PROG.	AGEN PROG
)41	754	500	4	801266A		755	C

ITEM	QUANTITY	COMPLETE DESCRIPTION (AND SPECIAL NOTES)	ESTIMATED COST
		REQUEST A TERM CONTRACT FOR THE PERIOD OF JULY 1, 1980 THROUGH JUNE 30, 1981, TO REPLACE Contract ST 79-264 for PURCHASE OF ALL TYPES OF LENSES & FRAMES AND REPAIRS FOR GLASSES. IN THE EVENT ADDITIONAL TECHNICAL INFORMATION OR SPECIFICATIONS IS REQUIRED, CONTACT Mr. Mike McKenzie, Administrator, Medical Assistance Unit - Ph. 371-2385.	

NOTE: List Prospective Vendors on Reverse Side of Page 1

Items covered by this request comply with all applicable State and/or Agency Laws, regulations and practices. Funds are available to purchase.

Charles Bonkston — Purchasing Agent.
Name — Title

500-02-08

Revised July 1, 1971
M—1-74—79213—PP&SCo.

Bid Opening Address:
DF&A Building
3rd Floor
7th & High Street
Little Rock, Ark.

INVITATION TO BID
STATE OF ARKANSAS
OFFICE OF STATE PURCHASING
DEPARTMENT OF FINANCE AND ADMINISTRATION

Mailing Address:
Post Office Box 2[illegible]
Little Rock, AR 7[illegible]

Bid Number	Date Issued	Type of Bid	Purchase Request Number	Date and Time of Bid Opening

Commodity Classification	Buyer	Phone Number
Lenses and Frames		

FOR:	FOB:	Contract period or date delivery required:
Office of Medical Services Division of Social Services P. O. Box 1437 Little Rock, AR 72203	Using Agency	Delivery as requested July 1, 1980 - June 30, 1981

TO THE VENDOR ADDRESSED: Bids are invited for furnishing commodities in accordance with TERMS AND STANDARD CONDITIONS AND SPECIFICATIONS SET FORTH IN THIS "INVITATION TO BID". Bids must be received by the Office of State Purchasing not later than the date and time of the opening.

Item#	Quantity	DESCRIPTION	Unit Price	Total Price
		PLEASE LIST UNIT PRICES. AWARD WILL BE ALL OR NONE, BASED ON THE TOTAL OF ALL ITEMS. NO UP-CHARGE TO BE MADE ON OVERSIZED LENS. AT LEAST 95% OF WORK TO BE COMPLETED WITHIN FIVE (5) WORKING DAYS AFTER RECEIPT OF PRESCRIPTION. ARKANSAS SOCIAL SERVICES MUST BE GIVEN WRITTEN NOTIFICATION WEEKLY REGARDING THE REASON FOR DELAY OF ALL ORDERS NOT COMPLETED WITHIN 15 WORKING DAYS OF RECEIPT OF PRESCRIPTION. THIS CONTRACT WILL COVER ALL AGES. FRAMES MUST BE EYE SIZE 52 OR SMALLER. THE CONTRACTOR MUST PROVIDE A TOLL-FREE INQUIRY LINE TO BE UTILIZED BY MEDICAID PROVIDERS WITHIN THE STATE OF ARKANSAS. IF FRAMES SPECIFIED BECOME OBSOLETE OR NON-AVAILABLE DURING THE CONTRACT PERIOD, THE CONTRACTOR MAY SUBSTITUTE A SIMILAR FRAME AT		

DISCOUNT____% ____Days

Upon signing this bid, the bidder certifies that the "Terms and Standard Conditions" and specifications have been read as set forth in the "Invitation to Bid", understands such and agrees to be bound by these "Terms and Standard Conditions" and specifications when a contract is entered into pursuant to this "Invitation to Bid". The bidder also agrees that this bid incorporates the "Terms and Standard Conditions" and specifications of this "Invitation to Bid" and is the complete and exclusive statement of the terms of the agreement between the parties, which supercedes all proposals or prior agreements, oral or written and all other communications between the parties relating to the subject matter of this "Invitation to Bid".

UNSIGNED BIDS WILL BE REJECTED

Name of Firm	Phone No.	Arkansas Tax Permit #

Business Address: Street	City	Zip Code

Signature of Authorized Individual	Title	Date

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	
		A COST THE SAME AS OR LESS THAN THAT BID FOR THE SPECIFIED FRAME PROVIDED AGREEMENT TO THE SUBSTITUTION IS OBTAINED IN ADVANCE AND IN WRITING FROM THE DIRECTOR OF THE OFFICE OF MEDICAL SERVICES. THE CONTRACTOR MUST IDENTIFY AND TRACK EACH JOB BY THE APPROPRIATE MEDICAID RECIPIENT NUMBER OF THE INDIVIDUAL WHO IS TO WEAR THE PRODUCT. THE CONTRACTOR MUST RESPOND TO THE STATE OR THE PRESCRIBING MEDICAID PROVIDER WITHIN ONE DAY REGARDING THE STATUS OF ANY MEDICAID JOB IF FURNISHED THE APPROPRIATE MEDICAID RECIPIENT NUMBER. THIS RESPONSE TO INQUIRIES MUST ALSO INCLUDE THE EXPECTED DELIVERY DATE OF THE JOB AND THE REASON FOR DELAY OF ANY JOB NOT COMPLETED WITHIN FIVE (5) WORKING DAYS AFTER RECEIPT OF ORDER. THE CONTRACTOR MUST MEET THE TOLERANCE LEVEL FOR PRESCRIPTION REQUIREMENTS ESTABLISHED BY THE AMERICAN NATIONAL STANDARD PRESCRIPTION REQUIREMENTS FOR FIRST QUALITY GLASS OPHTHALMIC LENSES. THE CONTRACTOR MUST FURNISH THE OFFICE OF MEDICAL SERVICES, ARKANSAS SOCIAL SERVICES, WITH A MONTHLY REPORT NOT LATER THAN THE FIFTH WORKING DAY OF EACH MONTH WHICH WILL INCLUDE THE FOLLOWING DATA REGARDING THE PREVIOUS MONTH'S JOBS: (1) NUMBER OF ORDERS RECEIVED; (2) NUMBER OF ORDERS COMPLETED; (3) NUMBER OF ORDERS PENDING BY THE CATEGORIES OF 1-5 DAYS, 6-15 DAYS, AND OVER 15 DAYS FROM RECEIPT OF ORDER; (4) TOTAL COST TO ARKANSAS SOCIAL SERVICES OF COMPLETED ORDERS; (5) YEAR-TO-DATE TOTAL ORDERS COMPLETED; AND (6) YEAR-TO-DATE TOTAL COST TO ARKANSAS SOCIAL SERVICES OF COMPLETED ORDERS. SALES TAX WILL BE PAID BY ARKANSAS SOCIAL SERVICES ONLY WHEN BILLED ON MEDICAID CLAIMS IN CONJUNCTION WITH THE PRODUCT FOR WHICH THE SALES TAX IS BEING BILLED. THE CONTRACTOR MUST IDENTIFY SALES TAX ON THE CLAIM FORM AND CODE THE TAX WITH THE CODE SPECIFIED BY ARKANSAS SOCIAL SERVICES. ALL CLAIMS FOR PAYMENT BY THE CONTRACTOR MUST BE BILLED ON CLAIM FORMS SPECIFIED BY ARKANSAS SOCIAL SERVICES AND IN ACCORDANCE WITH INSTRUCTIONS ISSUED BY ARKANSAS SOCIAL SERVICES FOR COMPLETION OF THE CLAIM FORM. FRAMES PROVIDED AS A RESULT OF THIS CONTRACT WILL BE REPAIRED BY THE CONTRACTOR FOR SIX (6) MONTHS AFTER THE EXPIRATION OF THE CONTRACT.		

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	
		APPROXIMATELY 20,000 VISUAL PRESCRIPTIONS WERE PROCESSED BY ARKANSAS SOCIAL SERVICES DURING CALENDAR YEAR 1979. THE VOLUME DURING THE CONTRACT PERIOD OF THIS INVITATION TO BID IS NOT EXPECTED TO VARY SIGNIFICANTLY.		

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	

SINGLE VISION LENSES
Tillyer, Orthagon or approved equal

SPHERICAL LENS-MINUS

1. Plano to 6.00 $_____
2. 6.25 to 8.00 $_____
3. 8.25 to 20.00 $_____

SPHERES-PLUS

4. Plano to 6.00 $_____
5. 6.25 to 12.00 $_____
6. 12.25 to 20.00 $_____

PLANO CYLINDERS & SPHERICAL CYLINDERS PLUS OR MINUS

7. Plano to 6.00 - .12 to 3.00 $_____
8. Plano to 6.00 - 3.25 to 6.00 $_____
9. 6.25 to 12.00 - .12 to 3.00 $_____
0. 6.25 to 12.00 - 3.25 to 6.00 $_____
1. 12.25 to 20.00 - .12 to 3.00 $_____
2. 12.25 to 20.00 - 3.25 to 6.00 $_____

ISCELLANEOUS SINGLE VISION EXTRAS

3. Tints 1 - 4 $_____
4. Photochromic Tints $_____
5. Coated glass lens $_____
6. Frosted lens $_____
7. Prism to 5.00 D $_____
8. Assembled and rimless mounting $_____

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	

BIFOCAL LENS

ulti Focal 22 or 25 MM segment, flat-top, corved top or round barium segment type bifocal - up o 3.50 D additions.

PHERES - PLUS ONLY

9. Plano to 6.00 $_____

0. 6.25 to 12.00 $_____

1. 12.25 to 20.00 $_____

LANO CYLINDER & SPHERICAL CYLINDER

2. Plano to 6.00 - .12 to 3.00 $_____

3. Plano to 6.00 - 3.25 to 6.00 $_____

4. 6.25 to 12.00 - .12 to 3.00 $_____

5. 6.25 to 12.00 - 3.25 to 6.00 $_____

6. 12.25 to 20.00 - .12 to 3.00 $_____

7. 12.25 to 20.00 - 3.25 to 6.00 $_____

EXECUTIVE BIFOCAL SPHERES - ADDS TO 3.50 D

8. Plano to 6.00 plus or minus $_____

9. -6.00 to 20.00 $_____

EXECUTIVE SPHERICAL CYLINDERS - ADDS TO 3.50 D

30. Plano to 6.00 plus or minus $_____

31. -6.00 to 20.00 $_____

KRYPTOK BIFOCAL SPHERES - ADD TO 3.50 D

32. Plano to 6.00 plus or minus $_____

33. -6.00 to 20.00 $_____

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	

CRYPTOK SPHERICAL CYLINDER - ADD TO 3.50 D

4. Plano to 6.00 plus or minus $_____

5. -6.00 to 20.00 $_____

6. -6.25 to +20.00 $_____

MISCELLANEOUS BIFOCAL VISION EXTRAS

7. 3.25 to 6.00 Cylinder $_____

8. Cruxite or gray tints $_____

9. Photochromatic tints $_____

10. Trifocal $_____

11. Lenticular trifocal $_____

12. Slab - off prism (per lens) $_____

13. 28mm segments $_____

14. Prism in the distance to 5.00 D $_____

15. Assembled & rimless mounting $_____

PLASTIC LENSES

SPHERES - PLUS OR MINUS

16. Plano to 6.00 $_____

17. 6.25 to 12.00 $_____

18. 12.25 to 20.00 $_____

TEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	

ANO CYLINDERS & SPHERICAL CYLINDER PLUS OR MINUS

. Plano to 6.00 - .12 to 3.00 $_____

. Plano to 6.00 - 3.25 to 6.00 $_____

. 6.25 to 12.00 - .12 to 3.00 $_____

. 6.25 to 12.00 - 3.25 to 6.00 $_____

. 12.25 to 20.00 - .12 to 3.00 $_____

. 12.25 to 20.00 - 3.25 to 6.00 $_____

SCELLANEOUS SINGLE VISION EXTRAS

. Tints 1 - 4 $_____

. Frosted lens $_____

. Prism to 5.00 D $_____

. Assembled and rimless mounting $_____

. Cruxite, Tru-tone, Calolite & Cosmalita $_____

. Other tints $_____

LASTIC BIFOCAL LENSES

lti focals, flat-top, curved-top & executive, adds to 3.50 D $_____

. Plano to 6.00 plus or minus $_____

. -6.00 to 20.00 $_____

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	
		HERICAL CYLINDER		
		. Plano to 6.00 plus or minus	$_____	
		. -6.00 to 20.00	$_____	
		. +6.25 to +20.00	$_____	
		lti focal round seg., adds to 3.50 D	$_____	
		. Plano to 6.00 plus or minus	$_____	
		. -6.00 to 20.00	$_____	
		HERICAL CYLINDER		
		. Plano to 6.00 plus or minus	$_____	
		. -6.00 to 20.00	$_____	
		. +6.25 to +20.00	$_____	
		ASPHERIC CATARACT LENS (PER PAIR)		
		. Single vision (white) sphere +8.00 to +20.00 S Adds +2.00, +2.50, +3.00, +3.50 (22mm round segments)	$_____	
		. Sphero Cylinder, plus or minus, +8.00 through +20.00 S, -.25 through -.500 C	$_____	
		. Bifocals (White) Sphere +8.00 through +20.00 C	$_____	
		. Sphero Cylinder, plus or minus, +8.00 through +20.00 S, -.25 through -5.00 C	$_____	
		. Far Univorm Density, Cruxite, Trutone, Calalite & Cosmalita	$_____	
		. Other tints	$_____	
		RISM IN DISTANCE		
		. .25 to 5.00	$_____	

No.

INVITATION TO BID
CONTINUATION SHEET

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	

FRAME REPAIR

. Hinge (per hinge) $_____

. Rivets, shields & screws (per unit) $_____

. Pads, adjustable (per pad) $_____

. Soldering $_____

. Mounting old lens in new frames $_____

CASES

. Case, slip-in (standard) $_____

. Case, slip-in (plastic lenses) $_____

. Case, fold-over or hard shell $_____

TEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	

ARKANSAS MEDICAID FRAMES

WOMEN'S FRAMES

	NAME	MANUFACTURER	FRAME	FRONT	TEMPLE
5.	Applause II	Bausch & Lomb	$_____	$_____	$_____
7.	Basic	Bausch & Lomb	$_____	$_____	$_____
8.	Symphony	Bausch & Lomb	$_____	$_____	$_____
9.	Libco #1	Liberty	$_____	$_____	$_____
0.	Libco #2	Liberty	$_____	$_____	$_____
1.	Libco #3	Liberty	$_____	$_____	$_____
2.	Libco #4	Liberty	$_____	$_____	$_____
3.	Libco #7	Liberty	$_____	$_____	$_____
4.	Libco #9	Liberty	$_____	$_____	$_____
5.	Chairlady	Liberty	$_____	$_____	$_____
6.	Lady Exec	Liberty	$_____	$_____	$_____
7.	Essence	Martin-Copeland	$_____	$_____	$_____
8.	Wild Rose	Univis	$_____	$_____	$_____
9.	#1100	Universal	$_____	$_____	$_____
0.	Clic	American Optical	$_____	$_____	$_____
1.	Friday	American Optical	$_____	$_____	$_____

MEN'S FRAMES

2.	707	Bausch & Lomb	$_____	$_____	$_____
3.	Burbank	Bausch & Lomb	$_____	$_____	$_____
4.	Wharton	Bausch & Lomb	$_____	$_____	$_____
5.	Libco #5	Liberty	$_____	$_____	$_____
6.	Libco #6	Liberty	$_____	$_____	$_____

No.

INVITATION TO BID
CONTINUATION SHEET

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	

MEN'S FRAMES CONTINUED

NAME	MANUFACTURER	FRAME	FRONT	TEMPLE
Fortune	Liberty	$_____	$_____	$_____
Barnstormer	Art-Craft	$_____	$_____	$_____
Baccarat	Martin-Copeland	$_____	$_____	$_____
Matt	Martin-Copeland	$_____	$_____	$_____
#1200	Universal	$_____	$_____	$_____
Harvard	Universal	$_____	$_____	$_____
Cutlass	Universal	$_____	$_____	$_____
Brougham	American Optical	$_____	$_____	$_____
Reveille	American Optical	$_____	$_____	$_____
Stadium	American Optical	$_____	$_____	$_____

BOY'S FRAMES

Bavaria Jr.	Bausch & Lomb	$_____	$_____	$_____
Harvard	Universal	$_____	$_____	$_____
Young Barnstormers	Art-Craft	$_____	$_____	$_____
Wrangler	Art-Craft	$_____	$_____	$_____
Rough Rider	Art-Craft	$_____	$_____	$_____
Jr. Flyer	Univis	$_____	$_____	$_____
Prodigy	Fairfield	$_____	$_____	$_____
Toddle Goggle	Pathway	$_____	$_____	$_____

ITEM NO.	QUANTITY	DESCRIPTION	UNIT PRICE	

GIRL'S FRAMES

NAME	MANUFACTURER	FRAME	FRONT	TEMPLE
Hershey	Bausch & Lomb	$_____	$_____	$_____
Bavaria Jr.	Bausch & Lomb	$_____	$_____	$_____
Holly Hobbie #1	Liberty	$_____	$_____	$_____
Holly Hobbie #2	Liberty	$_____	$_____	$_____
Holly Hobbie #3	Liberty	$_____	$_____	$_____
Cherie	Art-Craft	$_____	$_____	$_____
Powder Puff	Art-Craft	$_____	$_____	$_____
Miss Graceful	Foremost	$_____	$_____	$_____
Little Flirt	Pathway	$_____	$_____	$_____
Toddle Goggle	Pathway	$_____	$_____	$_____

COMBINATION FRAMES

B-31	Bausch & Lomb	$_____	$_____	$_____
B-51	Bausch & Lomb	$_____	$_____	$_____
Ronsir	Shuron	$_____	$_____	$_____
Nusir	Shuron	$_____	$_____	$_____